Exploring Clinical Psychologists' Experiences of Their Work: An Interpretative Phenomenological Analysis

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Submitted in accordance with the requirements for the degree of

Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds

School of Medicine

Division of Psychological and Social Medicine

June 2021

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

Acknowledgements

Thank you to the eight Clinical Psychologists who took part in the interviews, for the insight and perspectives you shared so openly and for making my job as an interviewer so easy.

Thank you to my fantastic supervisor Fiona Thorne for your continuous support, guidance, and kind encouragement throughout this process. I could not have asked for a better supervisor. Thank you also to Carol Martin for sharing your valuable IPA expertise and advice.

And finally, a huge thank you to all of my family and friends for your endless encouragement and love during all of the ups and downs of the last three years.

Abstract

Introduction: The wellbeing of those working in the NHS is of increasing concern. Clinical Psychologists occupy a significant role in services and have a unique, multi-layered role. There is a limited understanding of the lived experiences of those working in this role in existing literature. The current study aimed to provide an in-depth exploration of the experiences of Clinical Psychologist's work, with consideration to both the challenges and positives of the many aspects of this work.

Method: Eight qualified Clinical Psychologists working in the NHS were recruited and took part in semi-structured interviews. The resulting interview transcripts were analysed using interpretative phenomenological analysis.

Results: Four interrelated superordinate theme emerged, each with several subordinate themes. These highlighted the significance of relational aspects of work for the participants (theme one: relationships are "key"). Areas of challenge also emerged from the participants' accounts, such as their experience of organisational barriers (theme two: barriers and blocks- "up against it"). A further theme emerged around the ways participants were affected individually by aspects of their work (theme three: impacts of the work). The final theme related to factors which appeared related to helping participants cope with the challenges of their role and motivate them in their work (theme four: coping and sustaining factors).

Discussion: The findings are discussed in relation to existing literature and psychological theory around workplace wellbeing, resilience, and the challenges and rewards of working in roles such as Clinical Psychology. These findings are considered in context of the limitations of the study, including potential methodological weaknesses. Key implications for practice are then discussed.

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CHAPTER ONE: INTRODUCTION

This research explored the experiences of people working as Clinical Psychologists, and the ways in which their work-related experiences affected them. This chapter aims to situate this issue within its broader context and provide a clear rationale for the research. This will begin by considering the current context of workplace wellbeing in the United Kingdom (UK), and summarising key theories of workplace wellbeing. An overview of the role of Clinical Psychologists in the National Health Service (NHS) is then given. These sections provide an important foundation for this research. Following this, literature concerning stress and wellbeing of mental health professionals and more specifically Clinical Psychologists is reviewed. Particular attention is paid to concepts of burnout, vicarious trauma, and vicarious resilience. Finally, gaps in the current literature are identified and a justification for this research is presented, along with the key aims.

1.1 The Context of Work and Workplace Wellbeing

Most working adults spend around a third of their waking hours in the workplace (Public Health England, 2019). It therefore follows that the experiences people have at work may have far-reaching consequences for their overall wellbeing. Work can form a significant aspect of people's identity, including their social and economic status, and being in paid employment is often linked to better quality of life (Clark, 2001; Haller & Hadler, 2006; Waddell & Burton, 2006). Despite this, work does not always have a positive impact on wellbeing, with issues such as workplace stress being common, and potentially leading to exhaustion and depression (Maslach et al., 2001; Shin et al., 2013).

As the largest employer in the UK, the NHS undoubtedly relies on the health and wellbeing of its workforce to function. Yet concerns have grown around the wellbeing of NHS workers, as highlighted in a 2009 review commissioned by the Department of Health (Boorman, 2009). The review underlined the need to prioritise staff health and wellbeing and highlighted the savings that could be achieved by reducing staff sickness absence levels. Several strategies were then developed, aimed at improving staff health and wellbeing at both individual and wider organisational levels, such as the Improvement Framework for Health and Wellbeing (Department of Health and Social Care, 2011).

Despite this, statistics continue to suggest high rates of sickness among NHS staff, with a sickness absence rate of 4.21 per cent in 2018-2019 in England (Health and Social Care Information Centre, 2019), a rate more than double the UK labour market average. Alongside this, recent results from the national NHS staff survey indicates continued pressures in the NHS, with results for 2019 highlighting that 40 per cent of those who took

part had felt unwell due to work related stress over the past 12 months, with this figure rising to 44 per cent in the results for 2020 (NHS Survey Coordination Centre, 2019; 2020).

The current political climate in the UK is also of clear relevance. The UK has been in an "age of austerity" since the deficit reduction programme initiated in 2010 by the conservative government. These austerity measures, largely focussed on reducing public spending, have contributed to a reduction in funding to the NHS as a proportion of national spending over the last decade (The Nuffield Trust, 2017). Additionally, it is suggested that welfare cuts and reforms have indirectly contributed to increased demands on the NHS, for example by exacerbating health inequalities, poverty, homelessness, and unemployment (Reeves et al., 2013). Staff shortages continue to pose a challenge, with estimates suggesting around 1 in 12 posts are unfilled (NHS Digital, 2019). Furthermore, the 2016 referendum and resulting withdrawal from the European Union has exacerbated political tensions in the UK currently, and the implications for the NHS remain unclear. More recently, the unprecedented impact of the Covid-19 pandemic has reignited debates around the value of the NHS workforce and funding of public services, alongside wider concerns around the immediate and long-term effects of the pandemic. Considering the significance of these issues, it seems important to keep in mind this context as an important backdrop to the current research.

1.2 Theories of Workplace Wellbeing

To understand and improve wellbeing at work, it is helpful to consider what constitutes 'good' work, or work that is more likely to have positive effects on wellbeing. Warr (2013) conceptualises wellbeing as comprising of two dimensions; pleasure and mental arousal, both ranging from low to high. As such, when both pleasure and arousal are high, work engagement is possible; characterised by a positive and fulfilling mindset, energy, effort and enthusiasm at work, and immersion in one's work (Schaufeli & Enzmann, 1998; Schaufeli et al., 2002). At the opposite end of this spectrum, where pleasure and mental arousal are low, stress and burnout may occur, a state of psychological exhaustion resulting from chronic stressors at work (Maslach & Leiter, 2016). To make sense of what contributes to workplace wellbeing, relevant literature from occupational psychology will now be explored. This includes theories concerning motivation, job satisfaction, and stressors around work.

Job satisfaction, the level of contentment a person feels regarding their job and the sense of accomplishment this gives them (Spector, 1997), is multidimensional and may be influenced by a wide range of factors (Mullins, 2008). Job design theories have attempted to make sense of how such factors may affect motivation and satisfaction at work. It is widely accepted that extrinsic and intrinsic rewards are central to motivation (Deci & Ryan, 2002).

In relation to work, the opportunity and frequency of extrinsic and intrinsic rewards may therefore result in greater satisfaction and motivation. Extrinsic rewards are tangible and transactional, such as salaries and benefits, whilst intrinsic rewards are personal, internal responses gained from meaningful work (Perkins & White, 2009). Intrinsic rewards include opportunities to take greater responsibility, engage in varied and interesting activities, participate in decision making, be autonomous, and experience personal growth (DeCenzo et al., 2010).

One of the first attempts to develop a theory in this area was the Two-Factor theory of motivation (Herzberg et al., 1959). This was developed through interviews with over 200 professionals regarding satisfaction with their jobs and highlighted the particular importance of intrinsic rewards. This theory suggests a clear distinction between 'motivators' which lead to job satisfaction and motivation, and 'hygiene factors' which are related to dissatisfaction. Hygiene factors are extrinsic factors, such as salary, status, and job security, which can if absent can lead to dissatisfaction, but their presence alone does not increase internal satisfaction and motivation. Alternatively, motivators are factors intrinsically related to the work itself, such as responsibility, meaningful work, involvement in decision making, and recognition, which are central in leading to job satisfaction.

Whilst Herzberg et al.'s (1959) theory usefully highlights the importance of intrinsic motivating factors, it has been criticised for a lack of consideration of how individual needs and values will affect how motivating different factors will be for different people (Tietjen & Myers, 1998). The Job Characteristics Model (JCM; Hackman & Oldham, 1976) addresses this. This model outlines five core job characteristics: skill variety, task identity, task significance, autonomy, and feedback. The presence of these characteristics gives rise to three 'psychological states': meaningfulness of the work, a sense of responsibility for work outcomes, and knowledge of results of the work. These states allow for more positive outcomes for both the individual and organisations, including greater job satisfaction and motivation. Importantly, this model suggests that the extent to which job characteristics lead to the psychological states and the extent to which these states then lead to positive outcomes is mediated by three individual and environmental factors. These factors are firstly, the strength of an individual's desire for personal development and growth ("growth need strength"); secondly, the level of relevant knowledge and skills an individual possesses; and thirdly, the individuals "context satisfaction" such as satisfaction with managers, co-workers and job security. In this sense, individuals who have higher levels of growth need strength, knowledge and skills, and context satisfaction, are more likely to reach the psychological states and in turn experience job satisfaction than those with lower levels of these factors.

A further relevant theory is Ryan and Deci's (2000) Self-Determination Theory (SDT). This theory considers the fundamental human tendency to move towards growth, facilitated through the satisfaction of three core needs: competency, autonomy, and relatedness. In a work context, this might involve the opportunity to master tasks effectively, work independently with a sense of control and involvement in decision making, and to develop meaningful connections with others (Renard & Snelgar, 2016).

Whilst these theories may account for factors affecting motivation and satisfaction, little attention is paid to factors which may detract from this and lead to negative effects such as burnout. One model which does attend to the interplay between work stress and motivation is the Job Demands-Resources (JD-R) model (Demerouti et al., 2001). According to this model, occupational stress results from an imbalance between demands placed on an individual and the resources the available to the individual to deal with those demands and attain their goals. Demands and resources could include physical, psychological, organisational, and social aspects of the job; for example, demands of workload and poor supervision, and resources of autonomy and career opportunity. When demands and resources are high, both stress and motivation will also be high, whereas when both are low, both stress and motivation will be low. Therefore, certain combinations of conditions would result in different outcomes, such as high demands and low resources leading to high stress and low motivation, increasing burnout (Schaufeli & Bakker, 2004). Furthermore, certain resources are suggested to buffer the effects of job demands depending on the work environment, such as performance feedback and social support. A strength of this model is that rather than solely focusing on one outcome, this can account for both negative and positive aspects of workplace wellbeing (i.e., both stress and motivation).

A final relevant model which also considers the interplay of factors in job satisfaction and burnout is the Areas of Worklife model (Leiter & Maslach, 2003). This model suggests that burnout occurs as a result of a mismatch between the individual and job, which can occur across six key areas: workload, control, reward, community, fairness, and values. Mismatches in any of these areas can lead to burnout, with greater mismatches between the individual and job increasing the likelihood of burnout. Alternatively, greater perceived congruence between person and role in these areas is linked to greater engagement and satisfaction.

The discussed theories provide valuable insights into the concept of workplace wellbeing and highlight the complexity of this phenomenon. It is important to note that these theories are not universally relevant and may be limited in their applicability due to assumptions that underlie them, for example in relation to the Western cultures in which they were developed. Determinants of workplace wellbeing and job satisfaction may vary in

importance due to differences between cultures, such as differences in emphasis on individualism versus collectivism (e.g., Hauff et al., 2015).

Clearly, there is no single factor which leads to better wellbeing at work, rather, this may result from an interaction between a range of personal and external factors, and the wider cultural context. Furthermore, whilst broad theories are useful in identifying generic factors affecting wellbeing, other factors may be specific to the type of work in question.

1.3 The Role of Clinical Psychologists in the NHS

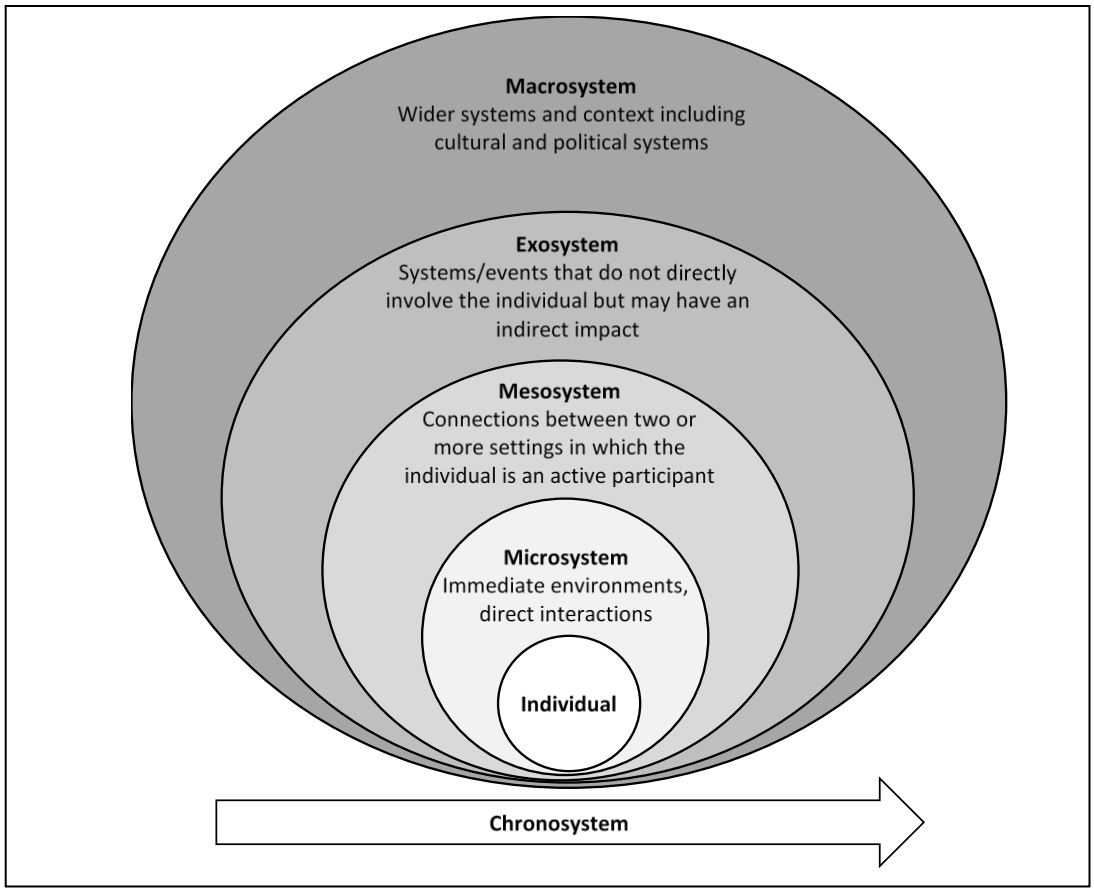
In giving context to this research and a rationale for the focus on Clinical Psychologists, it is important to understand the background and core features of this role. The role of Clinical Psychologists has grown and developed since this profession evolved in the early stages of the post-war NHS (Hall & Llewelyn, 2006). Indeed, Clinical Psychology has become an increasingly prolific profession, and is the largest of the 12 NHS-commissioned psychological professions (Psychological Professionals Network; PPN, 2018). There is an increasing recognition of the key position of Clinical Psychologists in a range of services, with core skills such as clinical leadership, service development, research and supervision being key to delivering national objectives such as those outlined in the NHS Long-term plan (NHS England, 2019). The recent increases in places for NHS funded Clinical Psychology training places (BPS Division of Clinical Psychology, DCP, 2021) perhaps illustrates the growing value of this role.

To work as a Clinical Psychologist in the UK, a doctoral level qualification (DClinPsy) is required which necessitates the development of a wide range of competencies including various clinical and therapy-based competencies, research skills, communication and teaching, and organisational and systemic influence and leadership (British Psychological Society; BPS, 2019a). The assimilation of theory, research and practice has been a long-standing feature of this role, defined as the 'scientist-practitioner' model (Raimy, 1950) in recognition of the scientific rigour underpinning the profession. Although still relevant, there are arguments that the scientist-practitioner model no longer fully reflects the role of Clinical Psychologists in the current NHS (Chang et al., 2008). As highlighted by Lane and Corrie (2006), this model may overlook the creativity and ability to draw on a wide range of sources necessitated in skills such as formulation. The increased emphasis on skills around indirect working and leadership also illustrates the changing nature of the role (Onyett, 2007; BPS, 2019a). What is evident is that the Clinical Psychologist role is unique in the combination and breadth of knowledge and skills, and ability to adjust and adapt to the changing needs of the NHS to access and promote psychological wellbeing for as many people as possible.

In line with this broad range of skills, Clinical Psychologists are often required to manage several roles in the workplace (such as therapist, supervisor, researcher, trainer, and leader) and competently shift between these roles (DeAngelis, 2002). Additionally, the relatively high NHS pay banding of Clinical Psychologists often places them as senior members of teams, providing supervision to other staff members and having greater involvement in managerial level decision making.

Considering the varied roles and levels of work of a Clinical Psychologist, Bronfenbrenner's (1979) ecological systems theory provides a useful framework for conceptualising this. The heart of this theory provides a basis for understanding human development and behaviour through the interactions and relationships that exist between an individual and the systems around them. According to this theory, human development and functioning results from interactions between an individual and four nested environments; the micro-, meso-, exo-, and macro-systems (Figure 1).

Figure 1. A visualisation of Bronfenbrenner's (1979) ecological systems model.

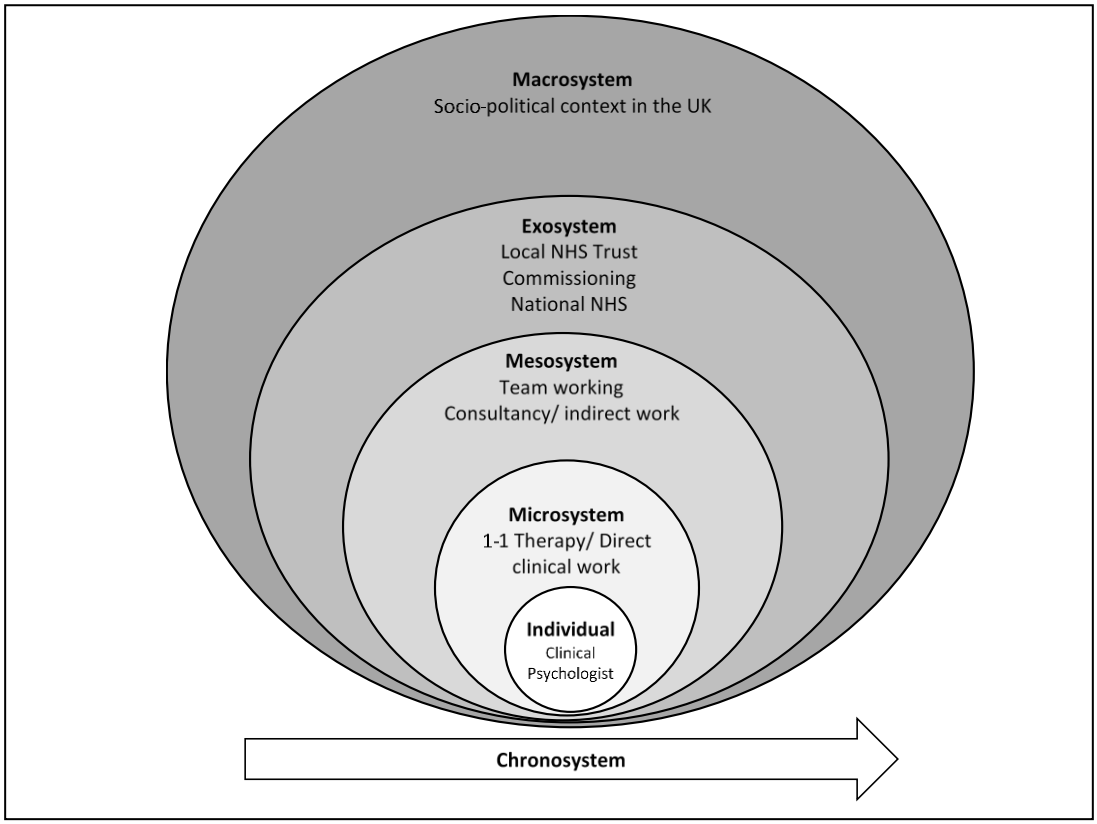


The interactions and interrelations between these systems are dynamic and change over time, as represented by the chronosystem (Tudge et al., 2009). Although Bronfenbrenner's model was developed to help understand a child's development in context, this model is now used more broadly (e.g., Lau & Ng, 2014; Browne, 2020) and is an inherently useful

framework for considering the various aspects of an individual's work-related experiences when there are multiple layers. This framework provides a more holistic overview of the systems that may influence each other and ultimately an individual, and captures the interaction between the layers, such as the 'ripple effect' that wider organisational and cultural changes may have.

Considering the role of a Clinical Psychologist, this model provides a useful representation of the systems that exist around this role and the ways in which these systems influence one another (Figure 2). This includes how an individual can have influence at these different levels, but also how changes or events occurring in these levels will in turn influence the individual. A unique aspect of the role of Clinical Psychologists is that they increasingly often occupy a role across many or all of these levels. As already highlighted, Clinical Psychologists commonly work at the meso-level, such as through consultancy or indirect working. Additionally, they are often involved in exo-system processes such as service development or commissioning. They may also undertake macro-level work, such as working towards wider policy change (Nelson & Prilleltensky, 2005; Browne et al. 2020). This highlights the importance of holding in mind a systemic framework in thinking about this role.

Figure 2. A visualisation of the role of a Clinical Psychologist using Bronfenbrenner's (1979) ecological systems model.



1.4 The Impact of Working as a Clinical Psychologist

As highlighted in the prior section, the role of a Clinical Psychologist can be highly varied. It therefore follows that there may be a range of aspects of the work which influence individual wellbeing. The following sections will provide an overview of the existing research into both negative and positive effects of working as a Clinical Psychologist, drawing on literature from research into similar professions such as mental health professionals or psychological therapists.

1.4.1 The Negative Impact of the Work

As emphasised by Johnson et al. (2018), the stress and absence rates of mental health professionals in general are higher than those of health care staff working in other sectors; recent data from NHS Digital (2020) concerning sickness absence rates for 2019-2020 suggest those working in mental health trusts take more sick days (a rate of 5.08 per cent) for example compared to those in acute trusts (a rate of 4.33 per cent). This is also starkly illustrated by survey-based data such as from the annual New Savoy Partnership survey, which consistently highlights high rates of distress among professionals working in psychological services in the NHS, with 43 per cent reporting feeling depressed and 42 per cent feeling a failure in the most recent results (Summers et al., 2020). Another relevant survey by the British Medical Association (BMA) in collaboration with the Royal College of Nursing (RCN) and the Association of Clinical Psychologists (ACP-UK) explored perspectives of mental health professionals in the UK. Of the 281 Clinical Psychologists who completed the survey, 44 per cent reported their workload was unmanageable or mostly unmanageable and 41 per cent reported feeling demoralised in relation to their work (ACP-UK, 2020). Such surveys provide an important snapshot of levels of distress among mental health professionals and Clinical Psychologists, although it is important to note that such surveys do not allow for causal relationships to be inferred.

Stress and burnout. Considerable research has focused on the issue of ‘burnout’ as an indication of workplace wellbeing. Burnout was first described by Maslach and Jackson (1981), as a psychological phenomenon of work-related attitudes, with three key dimensions: emotional exhaustion, feelings of disengagement or detachment from work, and a sense of low accomplishment. The associated Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) has become a key tool used to identify the experience of burnout in individuals. Burnout is evident across a range of occupations (Stalker & Harvey, 2002), but may be particularly prevalent in mental health professionals with estimated rates of between 21 to 67 per cent (Morse et al., 2012). Research from the UK suggests specific roles within mental health may experience particularly high rates of burnout, with a 2017 survey of

Improving Access to Psychological Therapies (IAPT) practitioners suggesting up to 69 per cent were experiencing burnout (Westwood et al., 2017). Another recent UK study which explored burnout in 298 psychological therapists (of which 57.7 per cent were Clinical Psychologists), found that 79 per cent were experiencing high levels of exhaustion and 58 per cent were experiencing high levels of disengagement (Johnson et al., 2020).

Vicarious trauma. As discussed, stress and burnout occur in mental health professionals, but these experiences are not unique to these roles. Vicarious trauma, and more recently the concept of vicarious resilience, are experiences specifically tied to work which involves some aspect of bearing witness to the trauma of another individual. A somewhat inevitable aspect of working in a mental health profession is hearing about traumatic experiences clients have faced. The negative impact of this has been considered in relation to several concepts, including 'compassion fatigue' (CF; Figley, 1999), 'secondary traumatic stress' (STS; Figley, 1995) and 'vicarious trauma' (VT; McCann & Pearlman, 1990). There is, however, much overlap between these concepts, and they are often used interchangeably in the literature which can lead to confusion (Makadia et al., 2017). Nevertheless, there is clearer consensus regarding the differentiation between STS and VT. For STS, the key feature involves a development of symptoms in line with Post Traumatic Stress Disorder (PTSD), such as intrusions, avoidance, and arousal (Figley, 1995). Alternatively, VT involves a deeper disruption to beliefs at a schematic level about the self, others and the world, resulting from cumulative exposure to trauma which over time changes a therapists' worldview and beliefs, in addition to changes at a symptomatic level (McCann & Pearlman, 1990).

Early research around VT and STS explored symptoms of PTSD and disrupted beliefs in trauma therapists (Pearlman & MacIan, 1995; Schauben & Frazier, 1995), finding positive correlations between length of time working with trauma, trauma symptomology, and disrupted beliefs. Later studies based in the USA found further evidence in line with STS, indicating that secondary exposure to trauma is associated with increased trauma symptomology in trainee therapists (Adams & Riggs, 2008) and psychotherapists (Brady, et al., 1999; Kassam-Adams, 1995). However, much of this research is difficult to compare as a range of measures have been used to assess VT and STS. Additionally, as highlighted by Sabin-Farrell and Turpin (2003), the reported correlations between trauma symptoms and trauma work in the key study from Pearlman and MacIan (1995) are weak, ranging from -.14 to -.20. Elwood et al. (2011) also drew attention to the lack of clarity from existing research, such as the limited evidence for VT among mental health professionals in studies which have assessed both components of this concept, disrupted beliefs and trauma symptoms. They also highlight the need to consider the impairment associated with symptoms, rather than the presence of symptoms alone.

Qualitative research has made a valuable contribution to the understanding of these concepts through providing detailed accounts of trauma workers' experiences, highlighting effects such as increased emotional responses and changes in cognitive schemas in psychologists and counsellors working with trauma (Bartoskova, 2017; Iliffe & Steed, 2000; Steed & Downing,), which fits with the conceptualisation of VT.

Importantly, much of the research into VT and STS is based in the US, focusing on therapists who may work exclusively with trauma. There is limited literature exploring these concepts in UK clinicians, or specific staff groups such as Clinical Psychologists. An exception to this is a recent study by Makadia et al. (2017), measuring the existence of VT and STS among a large sample of 564 UK trainee Clinical Psychologists using a large-scale survey. Questionnaires including the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004) and the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) were used, alongside questions around situational factors such as personal trauma history, exposure to trauma work, supervision, and quality of trauma training. The results suggested generally low levels of reported trauma symptoms, with mean scores on the STSS indicating "little or no" trauma symptoms, and TABS scores suggesting an "average" level of disruption in beliefs given the suggested cut-off from the authors. Additionally, there were no significant correlations between VT and exposure to trauma work or other situational variables. There was, however, evidence of a significant relationship between the amount of trauma exposure and STS, although this accounted for only 5.6 per cent of the variance in trauma symptoms. Situational factors were also found to be relevant, with level of stress of clinical work, other distressing clinical work, and quality of trauma training together accounting for a further 15.8 per cent of variance in trauma symptoms. As this was a quantitative study using measures of VT and STS, the authors draw attention to potential methodological issues in measurement of these concepts and highlight the potential benefit of future qualitative studies to inform VT measurement. Additionally, the authors speculate that trainees may not have had exposure to clients for long enough for schematic changes to beliefs to occur, as most trainees had a caseload of one to two trauma cases in the previous six months. Finally, there was no measurement of resiliency or growth in this study; it is possible that this was occurring, which the authors acknowledge may impact on measurement of VT.

Despite the limitations of the existing literature around the specific concepts of STS and VT, there is a clear suggestion that therapists engaging with clients who have experienced trauma are exposed to some negative effects of this. Although there is a lack of literature specifically exploring this in Clinical Psychologists, with trauma exposure being a likely aspect of most trainee and qualified roles it is reasonable to assume that Clinical Psychologists are vulnerable to these effects.

1.4.2 The Positive Impact of the Work

Job satisfaction. Despite literature suggesting relatively high levels of stress and distress among mental health professionals, this does not necessarily equate to low levels of satisfaction. A prominent study from Onyett et al. (1997) explored job satisfaction and burnout among 445 staff working across 57 community mental health teams (CMHTs) in England, using a range of measures including the MBI (Maslach & Jackson, 1981) and a job satisfaction scale from the Occupational Stress Indicator (Cooper et al., 1988). The findings suggested that despite high levels of emotional exhaustion on the MBI, total job satisfaction scores were also relatively high in comparison to another study of health care workers using the same measure (Rees & Cooper, 1992). The authors noted a possible link between high work commitment as a prerequisite to burnout, which may be more likely with high levels of job satisfaction. The co-existence of burnout and job satisfaction was also found in similar smaller-scale studies of healthcare staff at the time (Fagin et al., 1995; Prosser et al., 1996). In a later literature review from Onyett (2011), these findings were echoed in that whilst high levels of emotional exhaustion were indicated across many studies, the morale of mental health workers was relatively good. For example, Kumar et al. (2007) explored burnout and job satisfaction among psychiatrists in New Zealand, finding high levels of job satisfaction despite high rates of factors associated with burnout. The authors posited that the participants' level of passion and commitment to their jobs may act as protection from the emotional exhaustion experienced. Similarly, in a more recent study of burnout and job satisfaction among Psychologists in Ireland, whilst many participants reported high levels of emotional exhaustion and lack of personal accomplishment their overall job satisfaction was high (Roncalli & Byrne, 2016). There are exceptions to this pattern; for example, a study of staff working in a CMHT in the North of England found relatively comparable rates of stress and dissatisfaction (Carpenter et al., 2003), and a study of mental health social workers in England and Wales found similar consistency between stress, burnout and job satisfaction (Evans et al., 2006). These somewhat contradictory findings raise important questions about the relationship between burnout and job satisfaction, how these phenomena are measured and quantified, and what other factors may play a role in contributing to these experiences. Onyett (2011) highlights the challenges in distinguishing specific factors affecting morale and satisfaction and the complexity of this issue, although suggested certain factors as protective, including positive leadership, management, support, and supervision.

It is also of note that Clinical Psychologists in particular are often identified as a group with high levels of job satisfaction (Walfish et al., 1991; Norcross & Karpiak, 2012). This is supported by literature suggesting that psychologists may experience lower levels of burnout when compared to other mental health professionals such as nurses and social

workers (Billings et al., 2003; Nelson et al., 2009; Prosser et al., 1997; Lasalvia et al., 2009). In the UK, Clinical Psychologists have some of the highest levels of employment and retention in the NHS workforce, as highlighted by a longitudinal survey from Lavender and Chatfield (2016), which may be due to a range of factors but perhaps also indicates that for this group rewards or satisfaction outweigh the challenges.

Vicarious resilience. A further area of focus when considering the positives or rewards of the work relates again to the specific impact of working with individuals with trauma. Two concepts stand out as frameworks for understanding the positive opportunities that this work may create: vicarious resilience (VR; Hernández, 2002), and vicarious post-traumatic growth (VPTG; Arnold et al., 2005). VR was initially explored through interviews with therapists who spoke of the positive impact of working with survivors of torture (Engstrom & Okamura, 2004). Qualitative research with therapists working with survivors of political violence in Columbia has provided powerful accounts of the inspiration and hope gained from working with these clients (Acevedo & Hernández-Wolfe, 2014, 2017; Hernández et al., 2007).

VR is hypothesised to develop through clinicians experiencing the resilience of clients in relation to trauma, allowing for recognition of the human capacity to thrive in adversity, a shift in perspective about one's own life, and reaffirmation of the value of therapy (Engstrom et al., 2008). This has a positive impact on therapist's own well-being and may protect against the risks associated with trauma work. Informed by literature exploring VR, key elements of this concept have recently been developed into the Vicarious Resilience Scale (VRS; Killian et al., 2017), a tool to measure VR. These core features of VR as conceptualised by this scale are: changes in life goals and perspectives; client inspired hopes; increased self-awareness and self-care practices; increased capacity for resourcefulness; increased recognition of clients' spirituality as a therapeutic resource; increased awareness of therapist power and privilege; and, an increased capacity to be attentive to the clients' narratives.

Although much of the research around VR focuses on trauma therapists, and more specifically those working with victims of political violence, there is emerging research exploring this concept in other settings and populations. A qualitative study from Silveira and Boyer (2015) explored the experiences of four counsellors working with children who had experienced interpersonal trauma. They found evidence of VR through themes of hope and optimism, being inspired, and putting their own problems into perspective. A recent qualitative study in the USA explored the experiences of six psychologists in relation to VR, highlighting themes of privileging a shared journey, developing purpose and personal growth, deriving positive meaning and serving humanity (Michalchuk & Martin, 2019).

A similar but not identical concept to VR is that of vicarious post-traumatic growth (VPTG; Arnold et al., 2005). This stems from a recognition that people who experience trauma may experience surprising positive and adaptive changes to their self-perceptions, relationships, and philosophy of life, termed post-traumatic growth (PTG; Tedeschi & Calhoun, 2004). Arnold et al. (2005) highlighted how a similar process may occur vicariously through providing therapy to survivors of trauma, resulting in increased sensitivity, compassion, insight, tolerance, and empathy. A literature review from Manning-Jones et al. (2015) summarised research into VPTG in a range of professionals, including therapists and social workers, highlighting key findings such as shifts in values, spiritual growth, and improved interpersonal relationships, which align with traditional conceptualisations of PTG. Additionally, they noted some aspects of growth unique to VPTG, namely around a greater appreciation of the value of their professional identity, and a greater sense of competence. A key difference to VR is that there is an emphasis of growth in VPTG, suggesting a higher level of post-trauma functioning, whereas with VR this is not specified as necessary (Engstrom et al., 2008). Both VR and VPTG can be considered in relation to social learning theory (Bandura, 1977), in that these may develop through observational learning of a client's own resilience.

1.4.3 Factors Affecting the Impact of the Work

Alongside research exploring the existence of negative and positive effects of the work, interest has grown into factors which may mediate these effects. An overview of these factors is shown in summary box 1.

With respect to stress and burnout, a number of factors have been identified within large-scale systematic reviews as contributory to or protective against burnout. For example, O'Connor et al. (2018) found factors such as workload and poor relationships at work were consistent determinants of burnout among mental health professionals, whereas role clarity, autonomy, a sense of being fairly treated and access to regular supervision were protective. The authors do however draw attention to the high level of heterogeneity across studies and highlight the importance of considering the variation in findings across countries within the context of local and organisational factors, such as the NHS.

Another large systematic review of studies exploring burnout in applied psychologists working in the United States, Australia, and Europe suggested high work demands and working within the public sector as contributory factors (McCormack et al., 2018). Similarly, a recent international meta-analysis of studies exploring factors affecting burnout in psychological therapists explored the contribution of a wider range of environmental factors to burnout. They found that 'negative clientele' (i.e., the perceived difficulty of relationships with clients) was the factor most strongly associated with therapist burnout,

and subjective factors such as role conflict and role ambiguity were more influential than objective issues of caseload, work hours or income (Lee et al., 2020).

Other perhaps less obvious factors are also suggested to play a role, such as findings indicating that time spent on specific work activities, namely administrative or 'paperwork' tasks relate to greater levels of burnout among psychologists (Rupert et al., 2015).

Importantly, rates of burnout and associated levels of wellbeing may vary with the career development of Psychologists; Simionato and Simpson (2018) found higher levels of distress in younger, less experienced staff than more experienced Psychologists, and Dorociak et al. (2017) noted lower levels of burnout alongside increased job satisfaction and wellbeing as career progression occurred when considering psychologist wellbeing across career stages.

In relation to the specific experiences of VT and STS, several factors have been suggested to affect vulnerability to these experiences, although these should be considered in the context of the previously highlighted issues with the conceptualisation and measurement of these constructs. Some suggested factors which may relate to higher levels of VT and STS include having a personal history of trauma (Baird & Kracen, 2006; Pearlman & MacIan, 1995; VanDeusen & Way, 2006), a lack of peer support (Bride et al., 2007), quality of supervision (Ennis & Horne, 2003), length of experience working in the field (Kadambi & Truscott, 2004), and quality of trauma training (Makadia et al., 2017).

Additionally, researchers have attempted to explore factors which may be protective against these experiences or enable VPTG among therapists. Quantitative studies have found support for factors which may allow for growth, including greater levels of empathy (Brockhouse et al., 2011) and greater social support (Linley & Joseph, 2007; Mairean, 2016). There is also an increasing recognition that attending to and appreciating potential positive impacts may mediate against the negative impacts of the work, increasing growth and satisfaction (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Hernández-Wolfe et al., 2014; Silveira & Boyer, 2015). This could include promoting discussions about the concept and benefits of VR, actively seeking positive meanings from trauma work, and sharing positive stories with peers and supervisors (Silveira & Boyer, 2015). A study from Clauss et al. (2018) similarly highlights the potential value of interventions focused on attending to resilience, with an intervention of positive work reflection for caregivers leading to reduced emotional exhaustion and fatigue.

Other studies have begun to explore the relationship between these negative and positive consequences of the work. Some literature suggests a positive relationship between STS and VPTG; that is, as one increases so does the other (Kjellenberg et al., 2014; O'Sullivan & Whelan, 2011; Samios et al., 2012), in line with the notion that to experience VPTG one must first experience VT. Alternatively, some findings indicate a more complex

relationship. For example, Shiri et al. (2008a) found evidence of a curvilinear relationship between STS and VPTG in health-care staff vicariously exposed to political violence, where initial increases with STS were associated with increases in VPTG, but at a point VPTG plateaued and did not increase despite further STS. However, this finding was not replicated in a later study by the same authors exploring these concepts in other workers (Shiri et al., 2008b). A recent study exploring the relationship between STS and VPTG in a range of professionals in New Zealand suggested a curvilinear relationship for psychologists but not for other health-care professionals (Manning-Jones et al., 2017). This perhaps indicates that the relationship between these concepts is complex and may differ across groups.

Summary Box 1: Key factors which may be linked to the experience of workplace stress or burnout, and the development of VT or STS

Factors which may contribute to stress/burnout:

- High workload (i.e., high caseloads)
- Poor relationships at work
- High work demands
- Working within the public sector
- Perceived difficult relationships with clients
- Role conflict (i.e., inconsistent or incompatible demands)
- Role ambiguity (i.e., uncertainty around tasks and responsibilities of the role)
- Greater time spent on administrative or 'paperwork' tasks
- Less experience

Factors which may contribute to VT/STS:

- Personal trauma history
- (Lack of) peer support
- Quality of supervision
- Shorter length of time working in the field (less experience)
- Lower quality trauma training

1.4.4 Key Quantitative Research

The previously discussed studies give a broad overview of the range of factors which may contribute to or protect against the challenges of working in mental health professions or working with particular difficulties, such as trauma. As highlighted by O'Connor et al. (2018) contextual differences across countries (such as cultural and organisational factors) may account for some variation in terms of the relevance of different factors. As such, it is useful to consider more closely research based in the UK. Several quantitative studies have

explored stress, burnout, and related experiences among mental health professionals including Clinical Psychologists. Particularly relevant studies will now be considered in more detail. A snapshot of relevant factors is shown in summary box 2.

An early review of studies exploring stress among Clinical Psychologists suggested high workload, poor management, and lack of resources as factors contributing to burnout (Hannigan et al., 2004), although this may have limited current relevance when considering the changing role of Clinical Psychologists in recent years as previously discussed. More recently, Sodeke-Gregson et al. (2013) used the Professional Quality of Life Scale (ProQOL; Stamm, 2009) to measure the positive and negative effects of working with trauma in a survey of over 250 UK therapists, the majority of whom were either Clinical or Counselling Psychologists (69.6 per cent). Their findings suggested that higher age, time spent engaging in research and development activities, support from management, and supervision were related to positive outcomes. Alternatively, younger age and a lower perceived support from management predicted greater negative effects and burnout. Interestingly, therapists engaging in more individual supervision and self-care activities were at higher risk of secondary burnout traumatic stress, in addition to those with a personal trauma history. The design of the study limited further interpretation of this, such as whether therapists who were more distressed may have engaged in more self-care. Additionally, this suggests that the factor of supervision may be complex, as the authors highlight the notion of 'quality over quantity' in relation to supervision. Johnson et al.'s (2020) recent study specifically explored the contribution of the supervisory relationship to, and found a significant effect, with lower quality relationships associated with increased risk of burnout.

Although based in Ireland, a study from Roncalli and Byrne (2016) which focused on relational aspects of work is also worthy of consideration. A cross-sectional survey was used to explore job satisfaction and burnout among psychologists working in CMHTs in the Republic of Ireland. Their findings highlighted the importance of relationships at work as a potential mediating factor for burnout, and suggested specific key factors linked to greater job satisfaction: liaison with managers and supervisors, praise received, and teamwork.

Towey-Shift and Whittington (2019) explored factors relating to burnout in 132 staff working in an NHS Community Mental Health Team using a cross-sectional survey approach, with a particular focus on person-job congruence in line with Leiter and Maslach's (2013) Areas of Worklife model. The results suggested that low person-job congruence in workload, reward, and values were associated with increased burnout. This fits with a similar study from Merriman (2017), who found workload and limited rewards were related to emotional exhaustion in individuals working in an NHS Child and

Adolescent Mental Health Service, whereas perceived self-efficacy was linked to greater personal accomplishment.

Summary Box 2: Key factors affecting the impact of the work (in UK mental health professionals)

Negative factors (i.e., related to burnout, VT or STS):

- High workload
- Poor management
- Lack of resources
- Low person-job congruence (workload, reward, and values)
- Limited rewards

Positive factors (i.e., related to greater satisfaction/ protective):

- Age (higher age)
- Greater time spent on research/development
- Greater perceived support from management
- Quality of supervision
- Self-efficacy
- Positive relationships at work
- Communication and liaison with managers and supervisors
- Praise received
- Sense of teamwork

1.4.5 Key Qualitative Research

Although more scarce than quantitative studies, qualitative research around factors affecting stress and wellbeing has emerged, allowing for a deeper and more nuanced understanding of these experiences.

In a 2008 study, Papadomarkaki and Lewis explored Counselling Psychologists experiences of occupational stress and coping strategies, using Thematic Analysis. Four major themes emerged, including uncertainty at work, being oneself, relationships with significant others, and criticism of professional identity. The authors suggested that uncertainty was central to work-related stress, whereas meaningful and supportive relationships were highlighted as a source of coping. Whilst an important and novel study, this may not reflect a current picture of stressors and coping in the present UK context.

A second useful study explored the experiences of Clinical Psychologists working in Crisis Resolution and Home Treatment (CRHT) teams, using a grounded theory approach to analyse interviews with participants and conceptualise their experience of working with people ‘in crisis’ (Murphy et al., 2013). Three broad themes emerged: psychological and

clinical work, teamwork, and positive and negative aspects of CRHT working. These findings suggested the participants' felt valued in respect to their work and felt teamworking was central to this, but experienced some tension between how their role and professional skills and values fit within the service. Whilst a useful insight into these professionals experiences, this study was limited to those working in 'crisis' teams and so it is difficult to extrapolate these findings to Clinical Psychologists more widely.

Another useful example comes from Lamb and Cogan (2016), who explored work-related stressors and resilience through focus groups with a group of NHS mental health workers and a group of Samaritans' volunteers. Data from focus groups were analysed using Interpretive Phenomenological Analysis (IPA) and several key themes emerged. These included a perceived lack of control as a stressor, ways of building resilience (such as practical coping mechanisms and acceptance), the dual impact of values (in that values can be protective but also contribute to stress when compromised), and the effect of the environment. Whilst the authors noted similarities between the two groups, they also highlighted differences which they attributed in part to the different contexts of participants workplaces, such as resource pressures inherent in NHS settings and differences in working environments. Additionally, the use of a focus group may have inherently led to influence between participants and leads to difficulty drawing out individual voices, which is a key focus for IPA.

A recent study from Bartoskova (2017) used IPA to explore the experiences of 10 trauma therapists in Scotland, with a particular focus on VT and facilitators of VPTG. A number of themes emerged as relevant in fostering growth from the work, including social support, self-care, boundaries and life balance, managing self-expectations, and supervision. The authors drew attention to the ways in which participants spoke of their experiences in relation to mixed emotional reactions rather than separating out aversive and positive reactions. The acknowledgement that these impacts may overlap is a positive of this study, however the key focus on trauma may mean other potential sources of challenge and reward were overlooked.

Several unpublished doctoral theses have also used qualitative approaches to explore factors affecting the experience of working in mental health settings. Wright's (2017) mixed-method study included a Thematic Analysis of open-ended survey responses from a large sample (N=261) of NHS mental health clinicians, with a focus on burnout and resilience. The findings suggested resilience was aided by factors such as "love of the job" and "desire to help service users", whereas stressors such as bullying and exposure to physical abuse at work were detrimental. The use of a survey allowed for a large sample and breadth of responses, but did not allow for follow up questions or probes, which would have added further depth to the themes identified.

McLellan (2018) also used Thematic Analysis to identify factors affecting wellbeing in a sample of 15 Clinical and Counselling Psychologists. Five superordinate themes were found: personal support, 'traumatised systems'- the NHS context, positive and negative job aspects, inter-professional agents, and drive to improve staff wellbeing. This study highlighted the significance of organisational structures and influences e.g., the NHS context in relation to workplace wellbeing. The aim of using the data to develop a scale of assessing wellbeing in psychological practitioners, whilst important, may have limited the focus of the interviews to the construct of 'wellbeing', perhaps overlooking other ways people may have made sense of experiences. Additionally, participants were recruited via membership of the BPS' Division of Clinical Psychology, which may have limited the sample. Importantly, the research was also linked to a wider research agenda of developing a measure of wellbeing for psychological professions for the BPS Charter of Wellbeing and Resilience. This may have influenced the focus of the research and may relate to the specific focus on 'wellbeing'. The author also noted that at the time of this research, there were ongoing concerns around the future of the profession, and challenges with professional bodies, leading to the development of ACP-UK. This context may have influenced the findings, such as the emphasis on organisational pressures.

1.4.6 The Impact of the Covid-19 Pandemic on Staff Wellbeing

Due to the timing of this research, it seems imperative to consider the potential impact of the covid-19 on the wellbeing of staff, including those working in mental health settings. Since the early stages of the pandemic in 2020, research has begun to highlight the demands and challenges this has brought for staff working in a range of healthcare settings. As Clinical Psychologists work across a range of settings, they are likely to be affected to different degrees by these challenges, alongside any personal experiences that may be linked to the pandemic. There may also be more specific factors of relevance to mental health professionals; a recent study of UK mental health care staff highlighted potential impacts on staff, including anxieties around infection control, concerns about vulnerable service users, and the challenges of adapting to new ways of working, such as remote working (Johnson et al., 2021). Further potential impacts may be related to increased service demands in respect to the impact of the pandemic on the mental health of the wider population, staff shortages increasing workloads, and feelings of guilt due to self-isolation or absence (Byrne et al., 2021).

1.5 Summary and Justification of the Current Study

As highlighted through the previously discussed literature, the issue of workplace wellbeing in NHS staff such as Clinical Psychologists is of clear relevance in the current socio-political context in the UK. As such, there is a need to fully understand the nuances of working in this role and factors which may mediate some of the stresses and rewards of the work.

Theories around workplace wellbeing highlight the wide range of issues which may contribute to positive or detrimental outcomes at work generally, including features of a job and personal characteristics of individual employees. More specifically in relation to mental health professionals and Clinical Psychologists, a large body of literature has focused on one element of this role, namely direct therapy. The standout message from this literature is that providing therapy, particularly in relation to trauma, offers both risks and opportunities. Furthermore, attempts to understand factors which might affect these outcomes highlights a range of variables which may mediate how potentially harmful or rewarding this work is, including personal characteristics, support networks, and wider organisational factors.

Whilst the literature around trauma work is relevant to the work of Clinical Psychologists in that their training and banding will likely necessitate working with potentially high levels of trauma and complexity, focusing on this aspect of the work alone overlooks other potentially important factors, such as wider organisational and systemic challenges and opportunities. As discussed, there is a growing recognition of the unique role of Clinical Psychologists in occupying a range of different positions and working across many levels. This highlights the need to consider the broader experience of Clinical Psychologists, rather than focusing on any one aspect of the role alone, such as the provision of therapy.

Whilst there is a small amount of existing literature exploring work-related stress and wellbeing among UK psychologists, one study relates solely to Counselling Psychologists and was published in 2008 (Papadomarkaki & Lewis, 2008), and more recent relevant studies such as Lamb and Cogan (2016) have methodological issues making it difficult to draw clear conclusions. Further recent unpublished studies have added to this literature base, such as Wright (2017) and McLellan (2018), although again is limited by methodological quality issues and a narrow focus. Other research, such as the study from Bartoskova, focuses specifically on the impact of working with trauma and therefore overlooks other ways clinicians can be affected by their work.

There is therefore a gap in the literature for research exploring the experience and impact of working as a Clinical Psychologist, and the many different layers this work may involve. As such, a qualitative study allowing for a rich and nuanced understanding of the experiences of UK Clinical Psychologists is clearly warranted. It is hoped that a detailed

exploration of these experiences will allow for a richer understanding of the impact of working in this multi-layered role, including the rewards and challenges faced. This may allow for deeper conversations with stakeholders such as NHS organisations, training institutions and professional bodies, which in turn may promote dialogue around ways to nurture and develop the Clinical Psychologist role.

1.5.1 Service User and Stakeholder Input

Importantly, the focus of this research was shaped by service user and stakeholder involvement in its early stages. Whilst the term 'service user' is traditionally used to describe those receiving or using mental health services, there is a growing move away from using this within an 'us and them' dialogue in relation to staff member/service user, and an increased recognition that many individuals occupy both roles (Kemp, 2017; Tay et al., 2018; Grice et al., 2018). This was considered within the early stages of research in relation to 'scoping out' possible avenues of focus. As such, an informal request to generate ideas was made at a local BPS Division of Clinical Psychology event attended by Clinical Psychologists and stakeholders. The resulting ideas and views (Appendix 1) shared helped inform our decision to focus on the topic of the experience and effects of the work, whilst looking beyond direct ways of working to include wider team and organisational factors.

1.6 Research Aims and Questions

The overarching aim of the research is to develop an in-depth understanding of UK Clinical Psychologists' subjective experiences their work across different levels (such as individual work with service users, indirect work through consultation, providing supervision, research and training, and service development). In line with this, the key research questions are:

- What are the experiences of those working as Clinical Psychologists in the NHS?
- How does this work present challenges or negatively impact individuals?
- How do people cope with these challenges?
- What are the positives of this work, and what facilitates this?

CHAPTER TWO: METHOD

Within this chapter, a rationale for the choice of methodology and method for this research will be given. I will outline the methodological process in developing this research, with reference to the research paradigm, and my epistemological and ontological stance. Furthermore, I will describe the research design including the recruitment process, interview design and procedure, and process of analysis. Ethical considerations will also be explored.

2.1 Methodological Orientation

Within this research, a qualitative framework was used. Qualitative research primarily focuses on the exploration of meaning (Willig, 2012), and allows for the development of deep and contextual understandings through the analysis of rich, nuanced data (Mason, 2017). The appreciation of qualitative research is growing, with increasing recognition of the highly relevant position of qualitative research within psychology (Madill & Gough, 2008; Gough & Lyons, 2016). Considering the aims of this research were to explore subjective experiences and meaning making of Clinical Psychologists, a qualitative methodology was chosen. Interpretative Phenomenological Analysis (IPA) was chosen above alternative qualitative methods due to its emphasis on exploring lived experiences and individual sense-making. The choice of IPA will be further explored in later sections of this chapter.

2.2 Research Paradigm

The research paradigm is the overarching system or worldview that grounds research in its philosophical, theoretical, and methodological foundations (Guba & Lincoln, 1994). This acts as a compass, guiding the process of carrying out research in a certain direction (Gliner et al., 2016). As such, it is important for researchers to define a clear understanding of the research paradigm for a specified research question, as this will inherently inform the choice of methods for data collection and analysis (Mackenzie & Knipe, 2006). A research paradigm can be characterised in relation to its grounding in ontological, epistemological, and methodological philosophies (Easterby-Smith et al., 2008).

2.2.1 Ontology

Ontology concerns the nature of reality (Cohen et al., 2007). Ontological positions can be considered along a continuum, with the two extremes being realism and relativism. Realism assumes that an objective external reality exists, independently of human

perception, and is waiting to be discovered (Guba & Lincoln, 1994). Alternatively, relativism assumes that there is no single objective reality, that instead there are a multitude of different views on reality none of which can be considered true. A third position is that of critical realism, which lies somewhere between realism and relativism. Critical realism recognises that there is an external world independent of human consciousness, yet our experience of this reality is inherently influenced by social context (Danermark et al., 2002).

2.2.2 Epistemology

Epistemology concerns the theory of knowledge and learning; what can be known and how knowledge can be acquired (Cohen et al., 2007). Epistemological positions broadly align with ontological positions, with the extremes of positivism and constructionism mirroring realism and relativism. Positivism assumes that an objective truth can be discovered through studying the world using scientific principles, with the goal of research being to produce objective knowledge (Willig, 2013). Post-positivism adds a slightly different dimension to this, by acknowledging that the social context of researchers can affect the research process. Constructionism, in line with a relativist position, assumes that knowledge can never truly be "known" as an objective reality does not exist (Pring, 2004). Knowledge is seen as a construction of reality from a certain perspective, based on the individual experience and perceptions of the individual, and thus broad generalisations cannot be made. A third relevant epistemological perspective is that of contextualism (Madill et al., 2000). This is the position that knowledge is context-dependent, and that any knowledge produced will vary based on a range of factors, such as participants' and researchers' interpretations (Pidgeon & Henwood, 1997). Although contextualism shares the view of constructionism that there is no single reality and knowledge is subjective, it differs in that there is an acknowledgement that knowledge will be true in certain contexts, thus retaining a notion of truth that pure constructionism rejects (Braun & Clarke, 2013).

2.2.3 Developing an Ontological and Epistemological Position

Through understanding these ontological and epistemological stances I have developed a deeper understanding of my own position, and confidence in selecting a methodology that would best address the questions at the heart of this research. My own views regarding the nature of reality and knowledge are aligned to a critical realist and contextualist perspective, in that whilst I accept there may be a 'true' reality, this can only ever be known through the lens we view this, influenced by individual experiences and context. Through considering and reflecting on my position, I recognise that in the past I have valued a more realist perspective on knowledge, yet have grown to become more critical of this as my

understanding and experience with research has developed. For example, recognising that I feel strongly it is too simplistic and reductionist to assume people will interpret one type of experience in the same way. I believe my awareness of my own positioning is inherently important for this research, as self-reflexivity is central to many qualitative approaches, which by nature often rely on the researcher's subjective interpretation of data.

2.3 Methodology

Interpretative Phenomenological Analysis (IPA) was chosen as the methodological approach for this research. The rationale for this decision will now be explored, including a justification for choosing IPA over alternative qualitative approaches.

2.3.1 IPA

IPA is a qualitative approach which focuses on individual lived experience, attempting to see a specific experience through the unique 'lens' of the participant- their point of view (Smith et al., 2009). It encourages researchers to acknowledge that participants are experts in their own experience. Through this process, IPA can be used to establish a rich and meaningful interpretation of an individual's lived experiences (Smith & Osborn, 2015). IPA stood out as a methodology that would allow for and 'draw out' the depth of information about the individual experiences of interest to this research.

2.3.2 Phenomenology

A key foundation of IPA is phenomenology. As outlined by Smith et al. (2009), phenomenology was founded by Edmund Husserl in the early 19th Century, and later developed by several prominent philosophers, namely Heidegger, Merleau-Ponty, and Sartre. Phenomenology provides a means of studying individual interpretations and sense-making about the world. The core focus is on capturing the experience of a phenomenon as closely as possible (Giorgi & Giorgi, 2008). Concepts such as reflexivity are key to this, in that to 'get to' the experience itself one needs to recognise and step back from their own preconceptions and existing knowledge to attend to the experience itself.

2.3.3 Hermeneutics

A second core underpinning of IPA is hermeneutics, the theory of interpretation and meaning. This is inherent to IPA research, as the key focus is on an individual's interpretation or sense-making of their experience (Larkin et al., 2006). The process of

interpretation for IPA guides the lengthy and detailed analysis, which attempts to identify participant interpretations of their experiences. In doing so, the researcher becomes a part of the interpretative process, making sense of a participant's sense-making, or engaging in a 'double hermeneutic' (Tuffour, 2017). This highlights the importance for IPA research in both the participant's ability to articulate an experience, and the researcher's ability to understand them. This process is inherently influenced by the researcher's own views and preconceptions, and highlights the challenge of directly accessing a participant's experience (in line with Husserl's traditional aim of phenomenology). Instead, IPA aims to provide an account as 'close' to the participant's view as possible (Larkin et al., 2006).

2.3.4 Reflexivity

The aforementioned focus on interpretation and the researcher's role within this leads on to the importance of self-reflexivity in IPA research. A related and important concept is that of 'bracketing', which originates from Husserl's phenomenology in which an attempt is made to put aside prior knowledge to ensure the essence of people's lived experience remains intact. This ability to bracket ones existing assumptions and prior knowledge in order to let a phenomenon 'speak' has become a common focus of qualitative methodologies (Crotty, 1996; Snelgrove, 2014). The focus and expectations of this have been shaped by the recognition that researchers cannot put aside that which they are not aware of (Ahern, 1999), emphasising the importance of self-reflexivity within the bracketing process.

Whilst bracketing in the traditional sense is seen as a means to suspend presuppositions about the world and focus instead on what is actually presented in the data (Spinelli, 2005), the use of bracketing in IPA is more nuanced. As IPA is inherently an interpretative approach, rather than attempting to close off presuppositions, researchers are guided to work with and use them to enhance understanding (Tufford & Newman, 2010; Willig, 2013). This involves researchers developing self-awareness of how their own background, views, knowledge, and beliefs may influence their findings (Finlay & Gough, 2008). Through developing awareness of this, possible biases are brought into the researchers' awareness, and although may not be put aside completely their potential influence can be made sense of (Rodham et al., 2014). This balance between making sense of another's experience and reflection on one's own sense-making is described by Finlay (2003) as a process of 'hermeneutic reflexivity'. Finlay (2008) describes the 'dance' involved in this process, whereby there is a need to bracket out one's own initial responses to identify the meaning to the participant, yet also recognising and drawing on one's own perceptions to aid and deepen interpretations. The ability of the researcher to be self-reflexive is central to this

process, and can be aided by processes such as keeping a journal of reflections throughout the research (Biggerstaff & Thompson, 2008).

2.3.5 Idiography

A further key concept relevant to IPA is that of idiography, a focus on the 'particular', which in relation to IPA involves the commitment to a detailed analysis of each individual case (Moses & Knutsen, 2012). This contrasts a nomothetic approach which aims to develop overarching views around human experiences or behaviour (Smith et al., 2009). In line with idiography, IPA favours small and selective samples. Additionally, during analysis each participant's account is considered individually in detail before moving on, and each case is considered 'in its own right' before any cross-case analysis is made (Smith et al., 2009).

2.3.6 Ontological and Epistemological Positioning of IPA

In relation to the aforementioned ontological and epistemological positions, there is a growing recognition that IPA subscribes to a critical realist stance, with an emphasis on individual interpretations of reality (Reid et al., 2005; Finlay, 2006). This could also be considered as a 'light' constructivist stance (Eatough & Smith, 2006) compared to alternative methodologies. For example, discourse analysis (DA; Potter & Wetherell, 1987) is considered as a truly constructivist approach whereby language is seen as constructing people's worlds, whereas IPA places greater focus on making sense of individuals' experiences of thinking and being. IPA can also be considered as aligning to contextualism, in that the focus is on understanding a person and how they make sense of an experience within their unique context (Larkin et al., 2006).

2.3.7 Alternative Methodological Approaches Considered

Although other qualitative approaches were considered, IPA was felt to be the best fit for this research. Grounded theory (GT; Charmaz, 2006) is an approach which aims to develop new theories from data using a relatively large, heterogeneous sample. Although this was considered, it would not be an appropriate methodology for this research due to the homogenous nature of the sample (UK Clinical Psychologists) and the focus being on understanding the sense they have made of their experiences, rather than developing a theoretical account of their experiences. Additionally, GT is an inductive approach which attempts to limit biases to theory development, such as through avoiding extensive literature reviews prior to analysis (Glaser & Strauss, 1967) which would not have been feasible for the current research. Furthermore, I as the researcher will already hold inherent biases due to

my similarities to the potential participants (i.e., as a trainee Clinical Psychologist), and knowledge and experience in Clinical Psychology.

Thematic analysis (TA; Braun & Clarke, 2006) was also considered, as this method aims to find patterns in data and allows for the creation of detailed descriptions of dominant themes. TA is not grounded in ontological and epistemological positions, and thus can be used flexibly without subscribing to one single theoretical framework (Braun & Clarke, 2013). TA was considered as a possible appropriate method for this research, but IPA was felt to allow for a more nuanced, richer analysis due to its idiographic and interpretative focus. Additionally, IPA has been used in comparable studies (Bartoskova, 2017; Michelchuk & Martin, 2018) with similar sample sizes and settings.

Despite these points aligning IPA as an appropriate choice for this research, it is also important to consider the potential limitations of this approach. For example, the methodology in IPA has been criticised for lacking recognition of the integral role language may play in interpretations (Willig, 2013). However, Smith et al. (2009) argue that whilst the primary aim of IPA is to understand experiences, this is of course inherently tied to language, and thus language is always a consideration within IPA without a need to focus on it separately. A further criticism of IPA is whether this approach truly allows researchers to capture the deeper meaning of experiences, rather than opinions of these experiences (Tuffour, 2017). Essentially, this is dependent on the communication and interpretation skills of both the researcher and participants, and understandably warrants a high level of articulacy. This is itself may deem the research to be elitist, excluding less fluent participants. In managing this, the skills of the researcher are essential to ensure all participants are appropriately encouraged to allow for as rich and detailed data as possible.

2.4 Research Design

2.4.1 Design

As discussed, this study utilised a qualitative design to explore the work-related experiences of UK Clinical Psychologists. Semi-structured interviews were used to collect data which were then analysed using IPA. Interviews were chosen as an appropriate method, due to their fit with the aim of IPA in enabling participants to offer a "detailed, first person account of their experiences" (Smith et al., 2009, p. 56).

2.4.2 Sample

Participants were qualified Clinical Psychologists willing to talk about and reflect on their experiences of their work, and how these experiences had affected them. Although

trainees were also considered as relevant participants, the factor of training itself would likely present additional variables that are not the focus of this study. Additionally, trainee Clinical Psychologists are potentially 'below threshold' for experiencing concepts such as VT (Makadia, 2017), and would be unlikely to experience the same range of demands and rewards as qualified staff.

As IPA research is an idiographic approach and aims to provide in-depth accounts of experiences, detailed analysis of a relatively small number of cases is recommended (Smith et al., 2009). Although there is no ideal sample size for an IPA study, Smith et al. (2009) propose that between 4 – 10 participants is an appropriate sample for doctorate level research. A target sample of around 8 – 10 participants was planned, allowing for a broad understanding of the topic area whilst also allowing time for deep and detailed analysis of the data collected within the available time and resources.

2.4.3 Recruitment

Participants were recruited on a purposive basis, through the UK Facebook group for Clinical Psychologists. This is a private group, with all members based within the UK practicing within the clinical psychology profession. At the time of writing, there are over 5,700 members in this group. Quality checks are completed for all members of the group; they are asked to provide their HCPC registered name and number, or for trainees a photograph of their NHS identification card. This means that this group is only accessible to qualified or trainee Clinical Psychologists.

A brief advert (Appendix 2) was posted to the Facebook page for this group in July 2020, and again in September 2020, outlining details of the study and requesting interested participants contact the researcher via email. Participants who showed interest in the study by e-mailing the researcher were then emailed a reply. This included attachments of a participant information sheet (Appendix 3) outlining details of the study and inclusion criteria, a Research Participant Privacy Notice (Appendix 4) which summarised how personal data is used for research and their rights under the Data Protection Act (2018). Potential participants were asked to consider the information provided about the study and again to contact the researcher via e-mail if they were still interested in taking part. Once they agreed to take part in the study, participants were emailed a consent form (Appendix 5) which they were asked to compete and return (via e-mail). An appropriate time and date for the interview was then arranged, using the video-conferencing software Microsoft Teams.

Participants were recruited on a "first come first served" basis. A provision plan was made for those who contacted the researcher after the target recruitment figure was reached to retain their details and offer them a summary of the findings once available, however it transpired that this was not necessary as no further contact was made following the final

interview. In total, 12 potential participants contacted the researcher, and 11 of these met the relevant inclusion/exclusion criteria outlined below:

- Participants must have qualified from a UK DClinPsy programme and have spent a period of at least one year working in the NHS post-qualification as a Clinical Psychologist.
- Participants must be able to discuss specific experiences of their work in detail, via online video or telephone call platforms (Microsoft Teams).

One potential participant was not eligible to take part due to working solely in private practice, two potential participants did not respond to the email containing details of the study, and a further participant who did respond and wanted to take part had to later withdraw due to other commitments. This meant that by October 2020 a total of 8 eligible participants had taken part in online interviews. At this point it was decided in discussion with the research supervisor and based on reflections on the depth and content of the completed interviews that further recruitment was not needed.

2.5 Ethics

Full ethical approval (MREC 19-077, Appendix 6) was obtained from the University of Leeds School of Medicine Research Ethics Committee (SoMREC) on the 8th July 2020. The key ethical issues addressed within this are detailed in the following points.

2.5.1 Informed Consent

Informed consent was sought from all participants. Participants were provided with an information sheet and given the opportunity to discuss any questions with the lead researcher via email and prior to the start of the interview. They were also asked to sign and return a consent form prior to the interview (Appendix 5). Participants were made explicitly aware that their participation in the research was entirely voluntary, which was considered particularly important due to the relationship between myself (as a trainee Clinical Psychologist) and participants (qualified Clinical Psychologists). It was also acknowledged that any existing relationships with potential participants (such as current or previous supervisory relationships) could be considered a potential source of coercion, and therefore it was agreed that should this issue occur those participants would not be eligible to take part.

2.5.2 Right to Withdraw

Participants were made aware of their right to withdraw from the study. Participants were advised that should they wish to withdraw from the interview at any point during this, recording would immediately be stopped and any data recorded would be destroyed. Participants were also made aware that upon completion of the interview, they could request to withdraw their data for up to two weeks following this by contacting me by email. They were made aware that after this point, analysis may have commenced thus it would no longer be possible to withdraw their data.

2.5.3 Confidentiality

Efforts were made to ensure the anonymity of participants. Any identifiable information such as names, specific places of work, or other defining characteristics, were removed from data on transcription and a pseudonym was allocated to each participant. However, participants were made aware that there was a possibility of others recognising their identity, particularly if discussing very specific experiences. An additional issue around confidentiality concerned third party information. Participants were made aware that I would take the responsibility of removing any significant identifiable information around third parties they discuss, such as service users or colleagues, but that they may also wish to refrain from using details which may clearly identify another person such as their name or specific characteristics.

2.5.4 Data Protection

The University of Leeds security protocol for collection, handling and storage of sensitive research data was followed at all times. As interviews took place remotely (via video call), they were directly recorded and saved onto secure folders within the University of Leeds secure server, in line with the University Information Security Policy (available at https://it.leeds.ac.uk). Any electronic documents (e.g., Word documents or pdfs) relating to the research, such as consent forms or transcripts, were stored within a separate encrypted folder in these areas. Only the researcher conducting the study had access to this data.

2.5.5 Risks

It was acknowledged that during the interview participants may discuss distressing or challenging aspects of their work, and that this may be distressing for participants. This was managed through several processes. Firstly, participants were informed of the possibility of distress arising from discussing challenging issues within the participant information sheet.

Additionally, they were invited to discuss any concerns around this with me prior to the interview and were made aware that they could choose not to answer any questions or pause/stop the interview at any point. In cases where distress was noted, I was prepared to remind participants of these points and signpost them to further support if appropriate. Participants were also made aware within the PIS that should I become significantly concerned about their safety, appropriate safeguarding procedures would be followed. A further possible risk concerned my own exposure (as the interviewer) to potentially sensitive or emotional information through the interviews. To manage this, I anticipated this possibility and explored my emotional reactions to the interviews within supervision, seeking further support if appropriate.

2.6 Procedure

2.6.1 Development of the Topic Guide

The use of a guide containing a plan of areas to cover during interviews ensures the interview remains centred on the area of interest whilst facilitating a natural flow of conversation (Pietkiewicz & Smith, 2014). A topic guide was therefore developed, to give shape and structure to the interviews (Appendix 7). Questions were designed to elicit participants' personal experiences, thoughts, and feelings around their work, in line with the aims of the research.

The topic guide was developed in collaboration with the project supervisor, and several iterations of the guide were developed before the final version was agreed. This was partly due to my initial lack of familiarity with IPA, which grew throughout the process of this research. For example, initial ideas for questions felt too specific and focused for IPA research, which encourages open and expansive questions (Smith et al., 2009). Additionally, feedback on the topic guide was sought from a Clinical Psychologist with links to the University of Leeds course, who has significant experience in research using IPA. Recommendations from this feedback were incorporated into the topic guide, such as around the phrasing of questions and eliciting an appropriate depth of detail from questions.

A practice interview was conducted with a trainee Clinical Psychologist, who did not meet inclusion criteria due to being a trainee, but was able to reflect on experiences linked to their current and previous work as a trainee and assistant psychologist. She provided feedback which allowed me to further refine the questions, such as providing examples of different 'levels' of working within the main questions. I was also able to reflect on this process to develop my skills in interviewing, which helped me to recognise the value of using the guide flexibly to allow for a conversational flow to the interview and build

rapport, rather than rigidly following the questions. Furthermore, this helped me to feel more confident and comfortable about the interview process.

The final topic guide included a total of seven questions. A 'funnelling' approach was used, moving from general to more focused questions as the interview progressed (Dickson-Swift et al., 2007). The aim of this was to put the participant at ease and develop rapport so participants felt comfortable discussing their experiences openly as the interview progressed. Optional prompts were also included, which were used flexibly to elicit further depth and detail around the experiences participant's shared, or to gain clarification on their descriptions of experiences (Rubin & Rubin, 2012).

2.6.2 Interview Procedure

Interviews were conducted with each participant, via Microsoft Teams video-conferencing software. Although during the initial planning stages of research face-to-face interviews were considered, on weighing up the benefits and costs remote interviews seemed most appropriate. This became more relevant during the emergence of the Covid-19 pandemic in Spring 2020, around the time of my ethics application. As such, face-to-face interviews were disregarded at this point to reduce any unnecessary contact between the researcher and any participants.

Whilst there are noted concerns around conducting interviews remotely, such as loss of non-verbal information (Stephens, 2007) and the potential to impact rapport building (Shuy, 2003), research indicates that telephone interviews provide interview data of similar quality and quantity to face-to-face interviews, with no concerns around rapport building (Deakin & Wakefield, 2014; Vogl, 2013). Furthermore, remote interviews overcome issues of travel and cost, allowing a wider range of participants from different geographical areas to take part. Finally, remote interviews allow for greater anonymity and privacy, and may also overcome any concerns around researcher safety when interviewing participants face-to-face.

The interviews lasted between 51 and 87 minutes and were audio recorded. At the start of each interview, participants were reminded of the aim and focus of the research, and their consent to taking part was revisited. Participants were asked if they had any questions prior to and following the interview. Some participants made reference to potential identifiable information due to very specific aspects of their work or experiences, and were reassured that this would be considered when removing identifiable information from transcripts and selecting extracts to include in the write-up.

During the interviews, the topic guide was used flexibly, and participants often covered areas of interest without the need for further prompting. Participants' own language was used when possible, such as when I asked clarifying questions. This process enabled a more

natural flow to the interviews and allowed for the conversational tone that IPA encourages (Smith et al., 2009). At the end of each interview, demographic information was collected, including age, gender, ethnicity, work setting, and number of years qualified. This was done at the end of the interview rather than at the start to avoid unnecessary repetition of information that often naturally arose during the interview process itself, and to avoid shaping the interview as a "question and answer" format. Following each interview, I made note of any immediate personal reflections, which were then later referred to during analysis. Any key observations around non-verbal communication were also noted, due to recordings capturing only verbal information.

Interviewing during the pandemic

An area which was important to consider throughout the research process but also specifically during interviewing, was the Covid-19 pandemic. The pandemic has had a widespread impact on the NHS, directly increasing demand for many services and changing the ways people including Clinical Psychologists worked, such as increased remote working. Additionally, the pandemic had a personal impact on many people, such as experiences of illness or isolation, and the potential impact on individual wellbeing. I was mindful of the ways in which my participants may have been affected by this and wanted to acknowledge this without encouraging a set focus on the pandemic within the interviews. This helped inform the decision to ask participants to reflect on recent examples they could recall in detail, but that could be prior to the pandemic if this felt easier for them to discuss. Additionally, asking for descriptive details about events they spoke about allowed clarity around if and how the pandemic may have contributed to the experience. I also reflected on the ways in which data collection may have been shaped by the pandemic in supervision and within my reflexive journal as the interviews progressed.

2.6.3 Transcription and Data Preparation

All interviews were transcribed verbatim and anonymised to remove any personally identifiable information, with each participant assigned a pseudonym. I transcribed the first interview myself, and the remaining seven interviews were transcribed by a University approved transcriber. Following transcription, I listened to the recordings whilst reading the transcripts to check for accuracy and make appropriate amendments. Table 1 shows the writing conventions used for transcription, and any further conventions used when presenting extracts in the results chapter.

Table 1. Writing conventions

Convention	Description
[sighs]	Description of participant behaviour
{location}	Information added/amended for context, or to ensure anonymity
[ ]	Utterances/comments from interviewer deleted (e.g., “yes”, “mhm”)
...	Short pause
.....	Long pause
(merged)	Extracts merged from different parts of a transcript

2.7 Data Analysis

Within this section, an overview of the analysis process is given. Although IPA is a flexible and iterative approach, there are common stages generally followed in analysis (Smith et al., 2009). The stages of this process are summarised in Table 2. Further details of key stages of analysis are then given.

Table 2. Stages of IPA

Stage	Task
1	Reading and re-reading of the first participant’s transcript
2	Making initial annotations in the right-hand margin of the transcript
3	Identify and develop emergent themes in the left-hand margin of the transcript
4	Searching for connections across emergent the themes and clustering related themes together to form superordinate themes
5	Moving to the next participant’s transcript; following steps one to four for each transcript, one at a time
6	Looking for patterns/shared themes across cases, connecting the themes as a group and identifying superordinate themes across the participants

2.7.1 Individual Analysis

Steps 1-2. Analysis began at an individual level, examining a single transcript in detail before moving on to the next transcript. Microsoft Word was used to organise the transcripts into a table with three columns, with the transcript in the middle column. I read the

transcript several times, alongside listening to the audio recording, to attempt to immerse myself in the data. During this process I began to make initial exploratory notes in the right-hand column of the table regarding my reflections and observations, such as how participants may have been feeling, my own feelings and responses, and any ideas or reflections on what the participant said. On my initial reading of the transcript, I naturally started to use a method Smith et al. (2009) describe as "free associating", in that I would comment on anything which seemed to stand out when reading and listening to the interview. On further reading of the transcript, I began to use a more systematic method to structure my comments, using categories defined by Smith et al. 2009) to differentiate between descriptive, linguistic, or conceptual comments. Descriptive comments related to the content of the data, such as summaries of key phrases or emotional responses. Linguistic comments concerned how the data was presented linguistically by the participant, such as the use of pronouns, pauses, repetition, and metaphor. Finally, conceptual comments reflected initial tentative interpretations around the meaning of what participants said, and were often written in a question format to attempt to develop new meanings of the data. Different styles and colours of font used to represent the different types of comment, as shown in the extract in Appendix 8.

Step 3. Using the descriptive, linguistic and conceptual comments, I began to construct emergent themes in the left-hand column of the table. These emergent themes captured and summarised my understanding of the comments in a more focused and interpretative way, whilst relating these to the key research questions. Themes were written as short phrases or sometimes as direct quotes from the participant data if these were felt to best capture the meaning of what was said. In developing the emergent themes, my intention was to try to capture a concise summary of my exploratory notes whilst retaining the essence of the original data from which they had emerged, rather than using overly abstract codes. This was facilitated by the table format used, which allowed me to easily refer between the initial notes and original transcript. After the initial development of emergent themes, I checked back through these and again tried to link these back to the original data and made note of relevant quotes and line numbers, to again attempt to ensure credibility of these themes. I then created a new Word document, where I copied and pasted a list of the emergent themes.

Step 4. Using the list of emergent themes, I began to cluster these into related ideas or concepts using procedures defined by Smith et al. (2009). This was an iterative process and involved several stages of clustering and re-clustering. This was aided by the use of the Word document which allowed me to save, and re-visit prior stages of this process as needed. The clustering process involved searching for similarities or differences between themes ('abstraction'), or identifying opposite poles of a similar construct ('polarization'),

whilst holding in mind the research questions and aims. During this process I began to develop ideas of overarching 'titles' for each cluster of emergent themes, although these were used tentatively and were refined as the analysis progressed. At this stage I also began to highlight themes which I was uncertain of and themes which appeared clearly less relevant were filtered out, in line with guidance from Smith et al. (2009). At times, emergent themes appeared to stand out and bring together other themes, so these became subordinate themes ('subsumption'). Following several iterations of clustering and re-naming, a list of subordinate and related emergent themes was reached for each participant. The associated line numbers from the transcript were maintained throughout this process to ensure themes could be identified in the original data. An example of clustered themes for one participant is shown in Appendix 9. At this point in analysis, I began to write the pen portraits for the participants (detailed in the Results chapter) which were then reviewed and amended after the analysis was complete.

Although analysis of each participants' data was completed prior to moving on to the next participant, at the latter stages of analysis I revisited and amended some aspects of earlier analyses due to feeling increasingly skilled in IPA.

2.7.2 Group Analysis

Step 5-6. Following completion of individual analysis, I moved on to searching for overarching themes across all data. This involved attempting to cluster the themes from all participants. To do this, all eight participants' subordinate clusters were printed out and separated. I then attempted to cluster the themes, moving and organising them into new group clusters. Again, patterns, similarities and differences were considered, and initial clusters were rearranged and refined as this process progressed. A photograph of this process is shown Appendix 10. As shared superordinate themes emerged, a table was developed which represented these, along with associated emergent themes (from all participants) and example extracts from transcripts. A section of this table is shown in Appendix 11. This stage of the analysis was particularly challenging as it involved trying to distil a large amount of data into much more concise theme names, whilst still capturing the participants individual themes. I therefore sought more guidance from my supervisor at this stage and requested feedback on the quality of theme development and theme names.

2.7.3 Credibility and Quality Checks

In qualitative research, it is important to consider the 'credibility' and 'trustworthiness' of the data to ensure its quality. This differs slightly from the more positivist concepts of reliability and validity common in quantitative research, with Smith et al. (2009) cautioning

against using a simplistic or prescriptive 'check list' to ascertain quality. Instead, broader principles such as those of Elliot et al. (1999) or Yardley (2008) are recommended. These guidelines provide an overview of principles of good practice in qualitative research, but as highlighted by Smith et al. (2009) should be used flexibly to suit the creative process of IPA. Elliot et al.'s (1999) guidelines which seemed particularly relevant for this study are outlined below, along with a summary of how each issue was addressed.

Owning one's perspective. This relates to the researcher's assumptions and values around the research topic, and their awareness of how this may influence the interpretation of data. To address this, I held a reflexive stance throughout the research in order to consider how my views may impact the interpretation of data. As such, a journal was kept throughout the study, in order to facilitate and record these reflections (example extracts are shown in Appendix 12). The process of keeping a journal also allows for an 'audit trail' and can help to evidence transparency (Vicary et al., 2017). Additionally, a reflexive statement providing transparency around my background and personal context is given in section 2.8. Reflections on each individual interview are included within the 'pen portraits' in the results chapter.

Situating the sample. This refers to having a clear description of the participants to allow for the results to be considered with respect to individual contexts. To address this, relevant demographic information was collected from participants alongside relevant contextual information, providing an overview of the sample. The pen portraits also provide useful contextual information about participants and the interview process, allowing for a clearer picture of the individual participants.

Grounding in examples. This involves using examples of data to illustrate and evidence the process of analysis and interpretations. This was addressed through using direct quotes from participants to evidence my interpretations, and continually checking back to the original data when developing themes and as the analysis progressed, referencing related line numbers from transcripts throughout.

Credibility checks. This concerns checking the accuracy and credibility of interpretations, to ensure they are reasonable and grounded in the data. To address this, several strategies were used:

- Transcripts were re-read several times, allowing me to consider the data from different positions and perspectives. Anonymous extracts of transcripts with notes were also regularly shared with my research supervisor to ensure transparency. During analysis stages, frequency of supervision increased to allow for this.
- 'Peer validity' checks were completed with another IPA researcher where we discussed anonymised, verbatim extracts of transcripts with one another via vide-call. This involved sharing a section of anonymised transcript, and requesting

feedback on possible interpretations. This allowed me to consider the data from a different perspective. For example, in one peer validity session, the way a participant spoke of their relationships with colleagues was suggested to reflect admiration, rather than my initial view of this as valuing others' roles. This alternative perspective added depth to my initial interpretation and allowed me to refine my associated emergent theme.

- Tables of emergent themes along with relevant transcript extracts were regularly explored with my research supervisor and constructive feedback was sought, which was used to inform further analysis. This involved presenting anonymised transcripts during remote supervisory meetings via video-call, and making annotations during discussions around possible interpretations and themes. Additionally, sections of transcripts were emailed to my research supervisor on several occasions and feedback was then discussed during meetings. This often involved my supervisor asking me to talk through how I came to an interpretation, allowing me to clearly explain and justify my analytical process.
- Anonymised extracts were discussed within an IPA research peer group; discussions around how different individuals had approached interpretation allowed me to consider different perspectives to analysis, in addition to seeking feedback regarding my own interpretations.

2.8 Reflexive Statement

Developing a reflexive statement allows for researchers to consider their own influence on the research process, such as considering the role of one's personal situation, identity and past experiences (Willig, 2013). In addition to providing a clear acknowledgement of my own perspective, the following statement summarises how I came to this area of research and in turn may allow the reader to view the impact of how my background and experiences have impacted the research process and results. When writing this statement, I considered Langdridge's (2007) list of 'questions to encourage a reflexive approach to research' to guide my thinking, and drew on notes and extracts from my reflexive journal.

My background and values

I am a White British female in my early thirties, currently living in North Yorkshire with my partner. I was brought up in South Yorkshire. I am currently in my final year of training to be a Clinical Psychologist and have several years' experience prior to this working in a range of settings as a support worker and assistant psychologist, in both NHS and private organisations. I had always been drawn to Psychology and working within mental health settings, and I recognise that a part of the pull for me to do this relates to personal experiences of distress in myself and those close to me. During training, I have

developed a stronger idea of who I want to be as a psychologist and in particular a greater appreciation of systemic working, which I recognise in part relates to my growing awareness of politics and wider social issues in the UK currently.

The development of the research idea

In the early stages of thesis planning, I was unsure about the area I wanted to research for my thesis and initially felt quite anxious about the prospect of developing a project that would inherently form a large part of my training experience. However, through initial discussions of possible areas of interest and my increasing awareness of ideas such as burnout, vicarious trauma, and lived experience of mental health difficulties, I was drawn to ideas relating to staff wellbeing. I had also noticed during my experiences on different placements the sense of stress and challenge that many of my colleagues were experiencing, and the impact that the work could have on them. This was echoed in research emerging at the time highlighting rates of stress and mental health difficulties among those working in mental health settings, including Clinical Psychologists.

The initial stages of the project were shaped by reading around areas which may lead people to be negatively impacted by their work, such as the strain of bearing witness to trauma in clinical work, or the sense of frustration at wider services and resources. It stood out to me that despite this, Clinical Psychology is a popular and sought-after career and one which despite the challenges, many people value, enjoy, and thrive in. The concepts of vicarious resilience and post-traumatic growth highlight some of the ways in which even distressing or challenging work can lead to a positive process of change and growth. Whilst I was interested in these concepts and spent time considering research questions in these areas, in reading more widely I noted overlapping and sometimes confusing ideas, and a sense that the 'whole picture' was often overlooked. This ultimately led me to consider a broader area of focus for the research; essentially, what is it like working as a Clinical Psychologist in the NHS?

Reflexivity as a journey

Throughout the research process, I have tried to remain mindful of how my prior experiences and views may have shaped the research. I have kept a journal, which I have used to record key thoughts and reflections since the early stages of the research. In doing so, I have been able to become more aware of my thoughts and feelings, and potential biases in how I have approached the research, the participants and analysis. Alongside this, supervision has been central in developing my self-reflexivity and awareness of how my identity and experiences may have impacted the research.

An example of my development of reflexivity was when I was encouraged by my supervisor to consider how my role as an 'almost qualified' Clinical Psychologist may affect the interviews, in relation to similarities between myself and the participants and the power

dynamics this may have created. For some participants, this may have meant they were more comfortable talking to me due to shared aspects of identity, however for others this may have created a barrier in that they may have felt pressure to present themselves as competent, or potentially minimise challenges of their work. This made me very aware of the importance of reiterating core principles when planning and starting the interviews, reminding participants of confidentiality and the semi-structured, flexible nature of the process. Reflecting on power also helped me to recognise my own desire to come across as competent during the interview process, as I was mindful that participants could be potential future colleagues or supervisors. Becoming aware of this at an early stage helped me to notice and label these feelings, and to mediate the impact. For example, following the first interview on listening back to this and discussing this in supervision I noticed there were several areas I would have liked to follow up on, but I had not wanted to 'push' the participant. In recognising this as a possible reflection of these power dynamics I was able to manage this in future interviews, reminding myself of my role as a researcher in the interviews rather than as a trainee.

Holding a reflexive stance throughout the research process has been a new experience for me, but one which I feel has naturally allowed me to feel very 'close' to the research and recognise the influence of my own assumptions and biases in my interpretations. Although it has been challenging, I have also valued and enjoyed the research process.

CHAPTER THREE: RESULTS

In this chapter, the results of the study will be presented. Firstly, an overview of participant demographic data is given, followed by an individual pen portrait of each participant. The pen portraits will draw on themes from individual analysis alongside researcher reflections. The group analysis is then presented, detailing superordinate and subordinate themes, supported by illustrative extracts and quotes from participants. Finally, reflections on the process of analysis are presented.

Within this section, it is important to acknowledge the double hermeneutic of IPA, in that the results reflect the researcher's attempts to make sense of participants' sense-making of their own experiences (see section 2.3.3). As such, the results represent one possible understanding of the experiences of the participants, although it is hoped that through transparency of measures taken to ensure credibility and rigour (see section 2.7.3) and the process of analysis, the rationale and stages of the interpretative process will be evident to the reader.

3.1 Demographic Information

Eight participants took part in the study, all of whom were female Clinical Psychologists working in different NHS trusts. To ensure participant anonymity and given that this research is likely to be of interest to and read by Clinical Psychologists, demographic information is presented as a summary in Table 3 rather than within individual pen portraits. Some information is however linked to participants within pen portraits or referenced within individual quotes when this was central in framing the context, but this is kept to a minimum.

Table 3. Summary of participant demographic information.

Demographic area	Participant data
Age	Between 30 and 45 years old (M= 37.25)
Ethnicity	7 participants: White British 1 participant: Indian
Sexuality	All identified as heterosexual
Disability	None reported a disability
Years qualified	Between 2 and 16 years (M= 6.63)
Weekly hours of work (NHS)	Between 22.5 and 37.5 hours (M= 27.19)

Weekly hours of work (Private)	Between 0 and 20 hours (M= 4.38)
Area of work	2 x Older Adult 2 x Adult mental health Specialist trauma service Neuropsychology Health psychology Forensic inpatient

Participants spoke of experiences within their work which held some personal meaning for them or stood out to them in some way. They were encouraged to draw on at least two clear examples of their work, each of which related to working at a different 'level' (as described in the research questions in Chapter Two). The word 'client' is used to refer to people accessing the services participants worked in, as this was the term most used by participants. The experiences discussed by participants included:

- individual work with a client;
- group (therapy) work;
- service development initiatives (e.g., to manage waiting lists);
- clinical meetings, e.g., MDT's
- non-clinical meetings;
- working with external agencies;
- developing and facilitating reflective practice groups (for staff);
- providing consultation to non-psychologist colleagues; and
- providing supervision to others.

3.2 Pen Portraits

Pen portraits are given for each participant to provide context to the interview data, with the aim of creating a more complete impression of each participant (Holloway & Jefferson, 2013). The pen portraits highlight the participants' motivation for taking part and a summary of the areas they discussed in relation to the research questions, drawing on themes that emerged through individual analysis and where relevant using direct quotes from their interviews. For readability, some theme names have been slightly amended. The pen portraits also include reflections around the interview process from the researcher's perspective. Table 4 shows a key of formatting used in this section.

Table 4. Formatting key

Formatting	Descriptions
"Italic text"	Quotes from participants transcripts
Emboldened text	Themes from individual analysis
Emboldened italic text	Theme names which are drawn from direct quotes

3.2.1 Jess

Jess was the first person to contact me regarding the research and seemed keen to take part. She was in her own home during the video call, and we had to manage some minor interruptions from her family during the call which felt a reflection of her busy home life. Jess was interested in the research because she *"wanted to contribute"* and noted that when she saw the advert, this resonated with her, in particular the experience of working across multiple levels. Jess had worked in the same service since qualifying several years ago and identified this as something important to her, as it had allowed her to develop deep and **meaningful relationships** with the team.

She spoke of two examples from her work in some detail, one around developing and running a therapeutic group and the other concerning a service development initiative to manage a waiting list. She naturally spoke about the benefits and drawbacks to her work, and although she highlighted the variety of her work as a positive, she also spoke repeatedly of feeling ***"spread too thin"*** and presented the role as being a careful **balancing act**. She also openly reflected on her **self-doubt** and the anxiety she experienced at times in relation to her work, alongside a sense of needing to prove her worth. An important reflection she expressed seemed to concern the experience of **power grapples** as a Clinical Psychologist and needing to walk a fine line between being powerful and finding a voice, versus being accessible to and liked by her team. She noted a learning point from reflecting on her experiences within the interview, in that she wondered about an unconscious process of pushing herself harder to prove herself as a Clinical Psychologist, questioning aloud: *"maybe I run round like a headless chicken just to show that I am worth what people pay me for me?".* Jess also identified **positive feelings** and her passion for her work was evident, describing this as a *"fire in my belly"* and remarking on several occasions that she enjoyed and even loved her job despite the challenges. A key aspect of this for Jess appeared to be related to having **freedom to pursue her values** in parts of her work, such as through developing new initiatives like the group she discussed.

The interview with Jess felt comfortable and warm from the start, and my impression of her as someone who valued being approachable and non-expert fit with the descriptions she presented of herself through her examples. Whilst I felt Jess was open about the challenges I

did wonder if she was holding back at times due to my position as a trainee, particularly whether her use of laughter and humour may have masked some of the frustrations she noted. Despite this, I felt she seemed at ease generally during the interview and often pre-empted my prompts and questions, meaning I spoke relatively little during the interview.

3.2.2 Katie

Katie told me she took part in the research as she was interested in *"the way we work as psychologists"* and felt the interview could provide her with some *"space to think"* about her role and work. She was working within a relatively new role and so during the interview also drew on experiences from her previous qualified role in a different setting. The experiences she spoke about related to working through consultation with an education establishment, and running a reflective practice group.

Katie expressed a real enthusiasm for her work and ways in which her work allowed her to find **passion and purpose** such as by finding opportunities to be creative and *"go off piste".* Katie also spoke a great deal about external pressures and demands outside of her control which could lead to feelings of frustration and hopelessness, and used metaphors to present a strong sense of her **battling against the system** both within her service and in relation to wider governmental policies. This seemed linked to Katie having a strong value around advocating for others, which whilst guiding her could also create friction in that she was sometimes torn between **balancing her own versus others' needs**, describing a real sense of duty to *"look after"* her team. Katie described a process of accepting parts of her personal as well as professional identity as valuable to her work, allowing herself to *"be a human"* and foster **meaningful connections** within her work. She acknowledged that she had been ***"shaped"* by the work** in different ways, being inspired by others as well as learning to accept herself. Within this, Katie recognised **celebrating the *"small wins"*** as valuable, allowing her to notice strengths in herself and others and sustain a sense of meaning from her work.

During the interview I noticed feeling a sense of admiration for Katie, in that I felt I shared some of her values and frustrations. At times I noticed urges to agree with her and I felt I needed to work hard to maintain my role as researcher during the interview, and I wondered if to some extent this impacted the interest I showed, as I noticed myself asking more questions and using more prompts than in the first interview.

3.2.3 Lucie

Lucie was drawn to the project as she had recruited from a similar population, but also recognised that she felt she worked in *a "lot of different ways across different levels"* and

felt it would be *"interesting just to kind of explore that"*. Lucie was the most recently qualified of all the participants I interviewed.

Lucie spoke about a piece of clinical work which was coming to an end, and the shared *"journey"* she had been on with this person. She described some of the obstacles and barriers which they had worked through together, and expressed a sense of inspiration from this, depicting the **therapy as a process of mutual growth**. She reflected openly on how this work had affected her, such as feeling tearful within sessions, and doubting her own skills. It felt like it was important for Lucie to talk about this work and almost as though this was part of her processing the ending. This work had a positive outcome, which Lucie identified as an exception to the norm but something she felt important to celebrate, which fit with a wider sense of her noticing and **attending to the positives**. There was also a clear sense that this work gave Lucie an opportunity to affect change and feel worthwhile, which she noted as a challenge in other areas of her work describing this as *"ground hog day",* expressing a sense of despondency about a lack of change in the service. This was linked to her feeling unable to pursue interests and values due to external obstacles, resulting in her feeling **stifled by barriers in the system** and experiencing a **loss of her anticipated role**. Lucie told me she felt *"powerlessness to change things on a big level"* but had found smaller ways to **nurture her values** in work and beyond work, such as through 1-1 therapy and by starting some private work. Lucie also touched on ways in which she coped with these challenges through **connections with others** in her professional and personal life. Change was an overarching theme of Lucie's interview, with the sense that in her clinical work this was a challenging and bumpy journey, but worthwhile in the end, whereas in relation to wider systemic change there was a sense of her feeling stuck and relatively powerless.

The interview with Lucie felt natural, and she was probably the participant I identified with most strongly possibly due to her being the most recently qualified. I could also relate to the sense of her expectations shifting as her experience grew. I felt some sense of sadness after the interview with Lucie as I felt her ambitions had been dimmed a little by factors beyond her control, but I also respected the way in which she was actively trying to work in a way which aligned to her values.

3.2.4 Sadie

Sadie told me she took part because she felt the research was relevant to her work, and the advert reminded her of the *"juggling act"* of being a psychologist. This notion of a juggling, or balancing act seemed to frame the rest of the interview, as the experiences she spoke about often related to feeling pulled in different directions and the challenges of

managing **conflicts in the role**. The interview with Sadie centred around two different examples of her work: running reflective spaces for staff, and a piece of consultation work.

Sadie immediately came across as someone very proactive in wanting to solve problems, and spoke through several examples of challenges and how she had addressed these. There was a sense of frustration when this was not possible due to rigidity or limits within the system, but a sense of her pushing against these limits and being **at war with external barriers**. In managing this, Sadie spoke of using her frustration to motivate her to find areas where she felt more able to influence change, such as through delivering training to the team to develop their skills, **pushing where it moves**. She also identified ways in which she could be more independent and creative as important to her, valuing autonomy and wondered whether this helped to protect her against becoming *"burnt-out"* which she identified in some of her colleagues, and enabling her to still enjoy her job. This also related to a theme for Sadie around acceptance and **adjusting her expectations of herself and her role**.

Many of the themes from Sadie's interview seemed linked to her navigating and maintaining her relationships at work, with this being both a positive and challenge for her. She expressed a real sense of **responsibility** to advocate for and support others, with this being both a motivator and a challenge as at times she would recognise that she put others needs before her own. This tied in with her valuing her relationships with the team and **using relationships to cope**; in that when facing challenges, she identified that *"I don't feel on my own with it".* This also related to Sadie describing the ***"tricky balance"* of navigating power and needing to belong** as she found herself pulled to want to be a part of the team whilst also feeling some guilt around the privileges of her role and power she held.

I felt the interview with Sadie seemed to focus more heavily on areas of stress and frustration. She used humour when talking about some of the difficulties but was generally very open and honest in reflecting on the challenges of her work. Sadie expressed a worry at the end of the interview that she had been overly negative and followed this by telling me *"I do actually really love my job!"* It felt important to her to state this and this felt driven by her own needs rather than wanting to present the role to me in a certain way.

3.2.5 Nat

Nat told me she was interested in the research due to having used a similar methodology for her thesis research and wanting to *"give back".* She also told me she was interested in the broad nature of the research question, and told me if this had been more focussed on one issue such as vicarious trauma, she might have reconsidered taking part.

Nat spoke mainly about two different situations which she described as *"challenging"*, the supervision of another staff member, and her experience of multi-disciplinary team

meetings. In discussing her role as a supervisor, Nat described **relational challenges** such as interpersonal difficulties between her and the supervisee. She spoke candidly about this although openly reflected on feelings of discomfort and guilt in naming how she was feeling with this individual, and it seemed these feelings did not fit with her expectations of herself as a *"tolerant"* supervisor. When speaking about her experience of team meetings, Nat identified feelings of frustration around her time not being spent well, and the process not being *"good enough"* for the team.

Although she recognised work relationships could be a challenge, Nat also spoke about her **work relationships as an *"anchor"*** and these being protective against stress. She identified a need to invest in and nurture these relationships to preserve them. Nat also identified the challenges of working in a service under pressure and balancing **multiple parts of her role**, and this leaving her with little emotional capacity to cope with new challenges, describing herself as having a ***"full glass".*** Feelings of **responsibility** also seemed particularly relevant for Nat, in relation to the stresses of being a supervisor and holding responsibility for another person, and a sense of her feeling a sense of duty to the team in advocating and making things easier for them.

Towards the end of the interview, Nat reflected that she had felt she had discussed quite negative experiences and expressed a worry that what she had spoken about did not capture *"how much I really love being a psychologist".* She touched on feelings of privilege and satisfaction from her work, but felt that perhaps she had been pulled to discuss challenges as these were ongoing issues. She also reflected pragmatically on how she finds a balance in choosing what she invests her time and energy into, allowing herself to show **compassion** to herself and *"let go"* of some things, giving her space to **hold space for what matters** and is more meaningful to her (such as individual clinical work and avenues for leadership).

The interview with Nat felt comfortable and I warmed to her quickly, appreciating her openness and reflexivity. I found it easier to remain in my role as researcher as I could identify less with the specific experiences she discussed, such as providing supervision to others which I had little experience of at the time.

3.2.6 Rose

Rose took part in the research as she identified with the research and recruitment process and wanted to support trainees, and expressed a curiosity around research generally, telling me she was *"interested in what people are doing"*. She worked in an adult mental health setting and her role involved managerial duties in addition to clinical work. Rose spoke about the process of developing and running a therapeutic group, her involvement in a waiting list management initiative. She also touched on supporting and supervising the work of others.

Rose spoke positively about the group she had set up, identifying this as something she was proud of and linking to a personal value around feeling able to be **innovative and forge new paths.** However, she also expressed frustrations that the group was not yet well resourced, and she had decided to pilot this before investing more time, to try to prove the value of this initiative. This was linked to wider frustrations at a service level, such as feeling restricted by external limits of the service and feeling conflicted with the dominant medical model in the service, relating to the themes of **working in a flawed system** and having to **balance many competing demands**. Rose expressed a sense of pragmatism around what she could achieve given these limits, and was able to **manage her self-expectations,** seeing herself as a *"fallible"* human, and holding clear **boundaries** with her time. This tied in with her being able to focus on the aspects of her role which she saw as most important, and holding in mind the *"core"* value of *"trying to help people"*. Rose described noticing and **celebrating the *"small wins"*** as helping her to stay motivated and remain hopeful and optimistic about what she could achieve. She also spoke about the **value of connections with others,** sharing her frustrations and feeling appreciated by her colleagues.

Rose took part in the video-call from her workplace, which was different to the other interviews which had all taken place from people's homes. This seemed to frame the interview a little differently and I quickly noticed that it felt more formal than the previous interviews. I found myself relying more on prompts and possibly saying more than I had done in other interviews, which I wondered if perhaps was linked to Rose perhaps feeling a little less able to speak as openly as she could have, due to being in her work environment. I also noticed myself worrying about taking up her time due to her being at work, and I felt I may have rushed the interview slightly. This seemed to fit with the content of the interview which gave a real sense of her as someone who valued her time, and her own description of herself as someone very *"task focused"*. Despite this, I felt we were able to develop a good rapport and the process felt more relaxed as the interview progressed.

3.2.7 Ali

Ali could not remember the details of the study at the start of the interview, but when I reminded her she recalled that she had decided to take part because the topic felt "*relevant"* and that she identified with the need for participants from her own experience as a trainee.

Ali spoke in detail about an event she had attended and presented a piece of work involving a therapeutic group she had developed. She described how some of the group attendees had spoken about their experiences during the event, and this being very moving and powerful. She spoke about this experience as generating hope and as a way she found **meaning from her work**. Ali also expressed anger that she had to *"fight"* for the group to

take place, resisting pressure to *"give in"* to wider service demands. This represented a clear theme for Ali of **fighting *"against the tide"*** and feeling she was often pushing against service and wider organisational limitations. Ali described a sense of powerlessness around this, describing herself as a ***"tiny cog in a big system".***

Ali also spoke about a piece of individual therapy work and the difficulties she had experienced forming a positive relationship with this individual, and experiencing **powerful emotions** such as *"dread and anxiety"*. This linked to a wider challenge of **navigating tricky relationships**, needing to tread carefully to manage and nurture a *"good enough"* relationship which could tolerate some stress. She saw this as key to her work relationships too, in that she felt invested in developing good working **relationships to help her cope** with frustrations and not feel alone in facing challenges. More broadly, Ali described **feeling overstretched** at work, finding it difficult to do what she needed to within her working hours, meaning she sometimes felt unable to do the job *"justice".* This tied in with her experiences of **self-doubt** and self-criticism around what she was able to do at work. She spoke of this through an Acceptance and Commitment Therapy (ACT) lens and spoke about valuing this approach in managing her own feelings, using a technique of cognitive defusion to label this as a story: *"you're not a good enough psychologist story".* This also provided a way of coping, allowing her to normalise and accept these doubts whilst pursuing the values she held and *"focus on the things that matter",* although she described this as *"tricky"* due to the wider systemic barriers already described.

Towards the end of the interview, Ali reflected on the experiences she had spoken about, explicitly recognising that she **treasured positive experiences** which felt meaningful (such as the group), and that this helped *"sustain"* her in her work, acting as a buffer against some of the challenges.

The interview with Ali felt warm, engaging, and interesting, but there was an undertone of anger and sadness throughout. Ali probably was the most open in expressing difficult feelings throughout the interview, using powerful metaphors throughout. I noticed myself feeling and relating to some of frustrations she spoke about, making it challenging to maintain my role as researcher. I felt able to manage this, although I had more of a pull to offer her validation at the end of the interview than I had with previous participants.

3.2.8 Sara

Sara took part in the study because she felt it was *"really interesting"* and something she would be able to easily talk about. She was working in a medical hospital setting, which feels important to draw attention to due to the time of the interviews taking place during the Covid-19 pandemic. This meant that some of Sara's experiences were more specifically tied to the impact of the pandemic than other participants, and should be kept in mind when

considering the results. Alongside reflecting on her ongoing experience of facilitating reflective practice, Sara also chose to speak about a piece of therapy work from her prior role in a mental health setting, as she had only relatively recently moved to her current position. Sara had been qualified for many years, and she made reference to her years of experience at several stages during the interview, reflecting at the end of the interview that this stood out to her as *"invaluable"* to her.

She spoke about **balancing responsibility and navigating power** as areas which she had to carefully navigate, such as noticing pulls to *"fix"* people or situations. In managing this she described a process of **accepting the limits** to what she could control and having realistic expectations of herself. In a similar sense, she spoke about focusing on finding creative and small ways to affect positive change with the staff and families she worked with, describing this as ***"making tiny holes"***. This also linked to noticing the **rewards** she got from her work, such as feeling appreciated and proud, and feelings of inspiration from her work particularly in relation to witnessing resilience in others, describing feeling *"privileged to be part of that journey".* A theme that seemed to link these areas for Sara was around developing genuine and **meaningful connections** to others, whether that was clients or colleagues, *"it's about connection".* This was valued by Sara in that she saw her ability to develop positive relationships as central to her work, but also emphasised some of the feelings of anger and frustration she felt on behalf of others. For example, she spoke about a sense of duty to care for the staff she was currently working with, supporting them through a highly stressful and traumatic time.

Towards the end of the interview, Sara spoke strongly about **systemic barriers** that made her work challenging, noting practical issues such as funding and resources but also more specific political frustrations in the context of the pandemic, seeing the impact on her colleagues and feeling pushed to work in ways which did not align with her values, describing this as leading to a *"moral injury".*

The interview with Sara felt powerful as she spoke passionately about both the rewards and challenges of her work. She noted finding the interview helpful in that it provided her some space to reflect on her job and attend to the positive aspects of this as well as the challenges, which felt especially important given the pressures of her service at the time.

3.3 Results of Group Analysis

Exploration of themes across participants led to the identification of clusters of similar themes, which were grouped accordingly and given representative titles. The results of this process are presented visually in a thematic map, shown in Figure 3. Each superordinate theme and corresponding subordinate themes are illustrated in Table 5, showing their representation across the sample.

The superordinate and subordinate themes are then discussed in detail, with supporting extracts used to ground these themes within the interview data. Where divergence was present, this is also explored, however there was a significant amount of convergence in the overarching themes presented. Line numbers from transcripts are given to indicate the start point of the extract. Where extracts are merged, all line numbers are given. Writing conventions shown in section 2.6.3 of the previous chapter are used.

Figure 3. Thematic map.

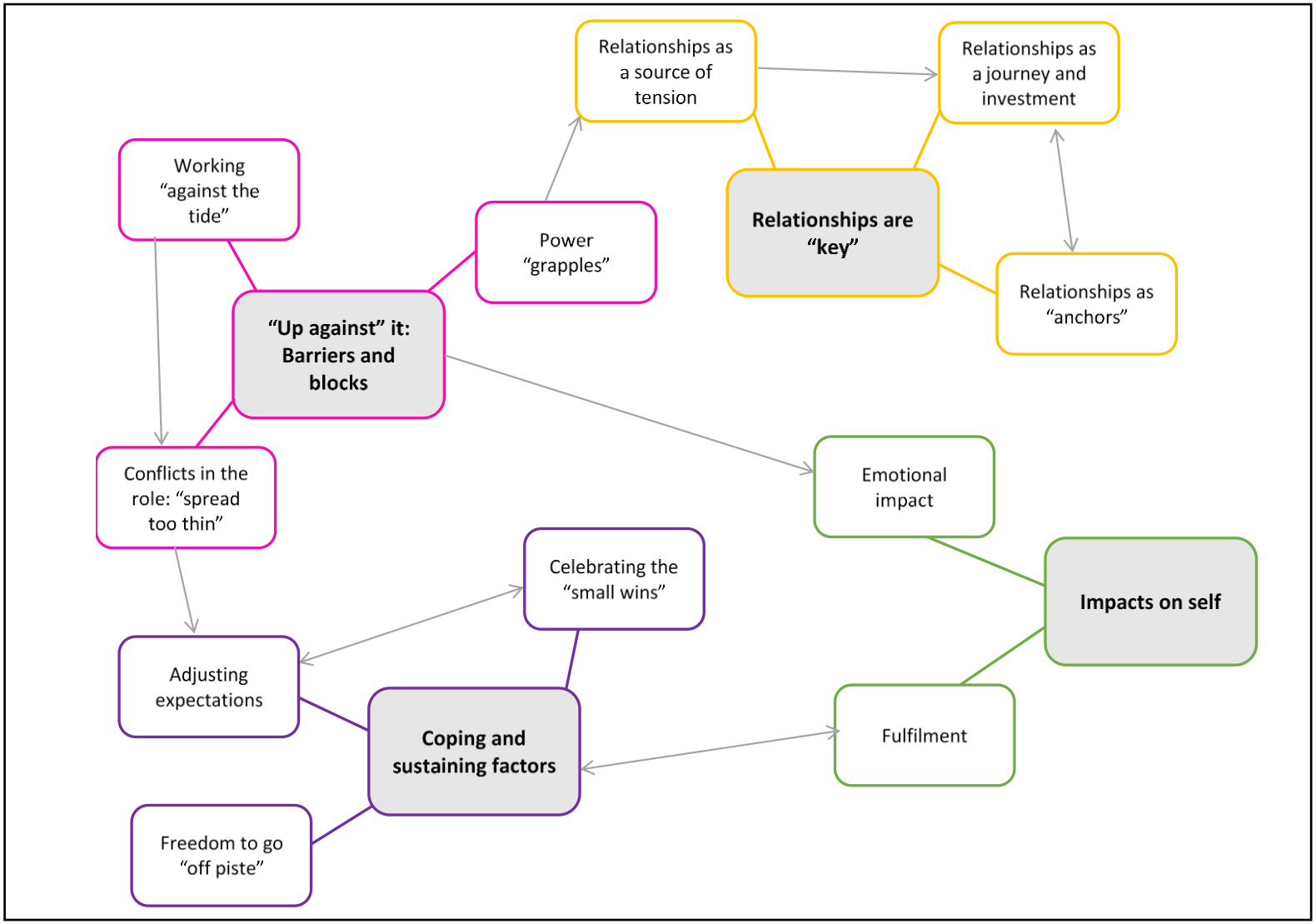


Table 5. Representation of themes across individual participants.

Superordinate theme	Subordinate themes	Participants							
		Jess	Katie	Lucie	Sadie	Nat	Rose	Ali	Sara
Relationships are key	Relationships as "anchors"	✓	✓	✓	✓	✓	✓	✓	✓
	Relationships as a source of tension	✓	-	✓	✓	✓	-	✓	-
	Relationships as a "journey" and investment	✓	✓	✓	✓	✓	-	✓	-
Barriers and blocks: Up against it	Working "against the tide"	✓	✓	✓	✓	-	✓	✓	✓
	Conflicts in the role: "spread too thin"	✓	-	✓	✓	✓	✓	✓	✓
	Power "grapples"	✓	✓	✓	✓	✓	✓	-	✓
Impacts on self	Fulfilment	✓	✓	✓	✓	-	-	✓	✓
	Emotional impacts	✓	✓	✓	✓	✓	-	✓	✓
Coping and sustaining factors	Freedom to go "off piste"	✓	✓	✓	✓	-	✓	✓	-
	Adjusting expectations	✓	✓	-	✓	✓	✓	✓	✓
	Celebrating the "small wins"	✓	✓	✓	-	-	✓	✓	✓

3.3.1 Superordinate Theme One: Relationships are "key"

This superordinate theme refers to the sense of relationships as being central to the participants' work as Clinical Psychologists. This included a sense of being able to develop strong relationships that could tolerate some challenge and felt secure. This was spoken about in relation to therapeutic relationships, but also in relation to relationships with other professionals, teams, and other organisations. The sense of relationships being highly valued also meant that participants seemed attuned to potential challenges or problems in relationships, and when this happened this could create tension and stress for them. In avoiding and managing this, participants' accounts highlighted how they saw relationships as evolving journeys, that required investment and nurture to grow and strengthen.

Subordinate theme one: Relationships as an "anchor"

Developing strong relationships and meaningful connections with others was spoken about by participants as a key aspect of their work across different levels. This included individual and group work, working with their colleagues and teams, supervisory relationships, and working with other organisations. This subordinate theme was named from a phrase Nat used when describing how her relationships with her team had given a sense of containment and stability at a particularly stressful time:

> *"You need, you, you have, you've, your team has to be accessible to you on a regular basis to provide that … that anchoring, that containment, that, that peer support. Just that opportunity to be together. Em is, yes so important, and we've had that. So, so actually I'm really grateful for that."* (Nat, 591)

Work relationships were also spoken about as providing belonging and connection. Sara referenced a sense of admiration for her colleagues, *"you just have a lot of respect for the people that you work with"* (Sara, 742), and Sadie shared the support she felt from her colleagues and explained that when facing challenges she felt supported by her team:

> *"We can talk about and reflect on and think about together. So I don't feel on my own with it, like I'm the only … kind of the lone voice. So I feel very supported."* (Sadie, 733)

The participants' accounts suggested that developing these strong relationships allowed them to withstand difficulties, with Jess explaining how when she has had to raise concerns with other staff or have difficult conversations, *"it is us having those good relationships that's helped us navigate that"* (Jess, 881). In relation to individual work with a client, Ali similarly spoke of the strength of their relationship as being central to them navigating difficulties in the work, *"it was just very hard. And I'm glad that em... we had enough of a bond"* (Ali, 386).

Lucie referred to her ability to form authentic relationships with clients, explaining that even when working with people very different to herself they could still develop a genuine connection:

> *"Even though you know we're patient and psychologist and we do work together, there's still those kind of pockets of like … you know like kind of friendly interaction and kind of finding common ground and it's just, it's just really nice."* (Lucie, 252)

Additionally, participants' accounts highlighted a sense of relationships being a core foundation to their work and role, with Katie summarising this when talking about her work in a consultancy role: "*the longer I was there, the more I was able to kind of build relationships with people really cos I think that's the key*" (Katie, 213). Rose also emphasised developing relationships as something she highly valued, and spoke about how working in a more senior role had reduced her clinical work but she was able focus on developing relationships through other parts of her work:

> *"And maybe that's the bit, it's about being with other people. Because like I said I've switched to a different, a step-up role, you lose some of the clinical bit so maybe I've replaced some of that working with people bit with staff element and supervision and stuff, because you're still working with people aren't you?"* (Rose, 508)

Subordinate theme two: Relationships as a source of tension

Participants also identified difficulties that came with developing meaningful relationships. This again was applicable to different relationships; participants were not only mindful of relational challenges in clinical work but also with their colleagues and wider team. Jess described the difficulties she had felt in trying to maintain positive relationships with her colleagues, explaining that when it came to addressing her needs and relationships, *"some of the other stuff with staff... it's muddier, kind of murkier work, that you have to tread carefully with really"* (Jess, 888). Difficulties in relationships within teams could have a widespread impact:

> *"There's arguments. There's disagreements. And it kind of effects the whole team! And then things will settle down for a little bit and then there can be another, so when tension is in the team, it's felt by the whole team."* (Sadie, 83).

This fit with other participant accounts of relationships as complex, at times confusing, and challenging. Nat was struggling with difficult dynamics within a supervisory relationship, describing herself as "*feeling around in the dark and not really, not really fully understanding what's going on within the dynamic between the two of us"* (Nat, 443). She reflected on the discomfort she felt in even discussing this issue, noting that *"nothing about it sits comfortably*" (Nat, 434), highlighting the sense of struggle within the relationship and with her own feelings about this. There was also a sense of needing to be cautious within

relationships to avoid conflict, with participants highlighting some of the relational challenges of individual work; Lucie spoke of worrying whether she might inadvertently offend or upset a particular client, and suggested a sense of this relationship being unpredictable, *"I kind of feel like I'm walking on eggshells with him"* (Lucie, 129). Ali described similar sense of unease and apprehension around her relationship with a client, *"she is probably one of the trickiest people I've worked with in terms of, feeling like, there's a powder keg about to blow off"* (Ali, 323), and acknowledging the *"physical, visceral response"* (Ali, 438) she had when thinking about this relationship.

Subordinate theme three: Relationships as a "journey" and investment

A final subordinate theme relates to the sense of relationships needing nurture and investment. This essentially allowed the participants to develop stronger relationships that could endure challenges, linking strongly to the two previous subordinate themes. Participants described different ways they invested in and cultivated strong relationships, in both practical and emotional ways. Participants spoke explicitly about investing time and energy in their working relationships and being available to their colleagues, *"Making sure that I am checking in with colleagues [merged] I'll give them a call. Just a quick, have a proper conversation with them! Just to make that connection"* (Nat, 576, 577). Jess highlighted that this investment was worthwhile and allowed her to feel able to rely on her colleagues if she needed them:

> *"A lot of our energy goes into continuing those good relationships. It's not always smooth! We don't always agree … but … kind of trying to nurture those relationships with our colleagues, cos we need them as much as you know they might need us for things."* (Jess, 267)

This sense of investment was echoed in participant accounts of clinical work, with therapeutic relationships depicted as a *"journey"* (Lucie, 162; Sara, 114) that required perseverance; *"it's kind of taught me to kind of stick with people… and kind of keep going through the difficult bits"* (Lucie, 252). There was also a sense of personal investment in these relationships, with Sara linking this to her identity as a mother as well as a psychologist. She spoke of this allowing her to develop a strong and meaningful connection with a young person:

> *"I think there was probably a bit of me as, as a mother, as a … kind of psychologist, as a, you know … the way, the way you look at a young person and you're really rooting for them? If that makes sense? You know you're thinking lots of life circumstances are against you. But I'm really rooting for you. And I think I, there was a real resonance."* (Sara, 248)

Participants also spoke about using compassion to help them develop relationships even when they struggled to relate to people, as Katie explained: *"I want to keep my own compassion for that person because she has her story too right? And I don't know her story. But I know that she, she must have her story"* (Katie, 229). Ali reflected on how she managed a challenging relationship with a client by holding her compassion for the individual, allowing this relationship to be repaired:

> *"There was a big part of me that felt like I can still hold on to that and kind of said "look I really want you to come back. I think we need to work through this, but it's absolutely your decision. So I'm going to leave that up to you but I hope that you do come back." So I hope I showed her some compassion [ ], and left the door open. And actually before our next session she rang me to apologise and said she did want to keep coming."* (Ali, 378)

3.3.2 Superordinate Theme Two: Barriers and blocks- "Up against" it

This superordinate theme developed from the way participants spoke about various obstacles and barriers in their work. This included a sense of participants feeling constricted by external limits and *"up against"* systemic barriers. The participants spoke about ways this contributed to them to feel overstretched, having to manage many different competing demands within their roles which could lead to them feeling overwhelmed. Relationships with power emerged as a further source of challenge, with participants noting ways in which power dynamics could create unhelpful patterns within their systems and within their own relationships with others.

Subordinate theme one: Working "against the tide"

The first subordinate theme for this group reflects the sense that participants often felt they were working against, rather than with, the wider system and organisation. Feelings of anger and frustration were evident from the way participants spoke of these issues. This theme's title came from Ali, who spoke passionately about feeling constrained by external barriers and expressed a sense of futility and powerlessness to change this:

> *"I think the way we set our services up, the structure of it. The kind of em … overly medicalised… set up. The lack of resources [merged] I feel like we're always kind of against the tide with it. And… em there isn't always then the time to reflect on these things. There isn't the time to do things differently. You're a tiny cog in a big system that seems intent on squishing a lot of it down rather than kind of helping things run smoothly."* (Ali, 425, 427)

Ali also reflected on her experience of being verbally praised and supported around an innovative project, but this not being given further support, leading her to feel angry and frustrated:

> *"I think that was kind of what probably sparked me being a bit pissed off to be honest because I was like, if this is what you think then … do something about it. Do you know what I mean? Em… And yet you know we don't have any more resources."* (Ali, 230)

Other participants also expressed a sense of feeling constrained by external limits: *"if management don't support it, then, you know, it's just not sustainable"* (Rose, 138), and feeling as though solutions or changes they identified might be talked about and verbally supported but not put in place: *"we were like trying to talk about the same things like what, what do we offer? What can we do that's innovative? But we haven't done anything since… em things are the same since the away day."* (Lucie, 430). The participants expressed a sense of feeling restricted and stuck by limits in their services that were often beyond their control, with Katie describing "*the biggest challenges are the, are the things that feel quite out of our power*" (Katie, 298), and feeling though she was *"up against a system"* (Katie, 319). The participants' accounts also suggested frustrations with wider barriers and funding. Sadie expressed a sense of frustration and separateness when talking about decision makers (i.e., commissioners) *"you don't have any less work to do. They just want you to squeeze it in because it's cheaper!"* (Sadie, 630-632). Jess described how she felt her service needed more Psychologists to function well, but a lack of funding meant this was not possible; *"there's no funding for it, it's not commissioned, it comes down to money"* (Jess, 383) and Katie expressed similar frustrations *"That should be free. That should be funded by the Government and it should be just embedded"* (Katie, 687). Sara identified this as a factor leading her to leave her previous service:

> *"It's a reflection really about how… our Government and our society and the wider, you know… influences, our experiences of our jobs… em… I don't think you can get away from that fact because I think we had appropriately funded services we wouldn't, I wouldn't have left."* (Sara, 884)

These issues meant that participants could feel they were not able to provide a service that best met the needs of their clients: *"not being able to really work with people as kind of, see them as people and what their needs are. Everything becomes a kind of... transaction"* (Ali, 368), or led them to work in ways which felt uncomfortable to them, *"sometimes I even hear myself, and I hate it, but talking about private therapy. Just as a, saying to people if it's financially an option for you? And I hate that that happens! That I have to do that"* (Sadie, 516).

The participants' accounts also suggested a sense of sadness or despondency around this changing, with Lucie reflecting on this towards the end of her interview:

"there are the… frustrations em… in terms of the sort of service that maybe [merged] I knew were there but hadn't really spoken about to anyone. Again because like, what, what's the point? [Laughs]" (Lucie, 643, 644)

Subordinate theme two: Conflicts in the role - "spread too thin"

The participants often spoke of the varied nature of their work and a sense of being extremely busy. Although some participants identified the variety of their work as something they enjoyed, they also described ways in which they felt stretched in achieving different demands or pursuing different areas of their work. Participants spoke about a sense of being constantly busy and feeling the demands of their role were somewhat unachievable with the time and resources they had: *"I feel like my to do list is like, never done. So it's like never ending and then you feel bad, because you put things off"* (Rose, 342) and feeling their time was consumed by many competing demands, *"you kind of quickly realise that oh I've, you know I've got to go to this meeting! I've got to do this report! And then … you know there's a crisis that happens and suddenly your whole day has gone."* (Lucie, 480). Sara spoke this sense of busyness leading her to feel her work could be reactive, and felt that earlier in her career she had more time to reflect:

"Even supervision can be quite reactive? It's like a bit of tick box sometimes you're like oh I've got to do this! I've got to do that! Is there anything needs doing now and this, sorted that out, sorted that, was there anything else on my list? Sometimes I think because we're so busy, I think when I, when you're a, maybe less far along, you have that hour, I was maybe … a bit more reflective on one case or whatever? But now and it's, it can be but it's quite busy. There's always stuff." (Sara, 820)

The impact of having many competing demands was highlighted by Nat who spoke of a metaphorical 'glass' being full, *"maybe if my glass wasn't so full, I could do that"* (Nat, 257), with this leaving her feeling she had less tolerance for new problems. Jess also conveyed feeling drained by the competing demands of her role, and this leading her to question whether what she was able to achieve was worthwhile:

"Sometimes I feel like I'm not doing a good job because I'm spread too thin. And that's hard! Because … you know you're using up so much energy … with your clients. Physical energy. Emotional energy with your teams and you come to the end of your day and you think, have I actually done anything? Have I done anything meaningful?" (Jess, 349)

The participants' accounts highlighted how feeling overstretched led to them having less time to pursue training or areas of personal and professional development (PPD) in that they had to make sacrifices to manage their workload, as highlighted by Jess: *"I don't get much time to read around cases, research and things like that. That just … that falls by the*

wayside. It's, the list is a mile long" (Jess, 371). Lucie spoke similarly of the difficulties in managing this balance, *"I've got like this motivation for it. But then other stuff catches up and then suddenly I've not looked at it for like 3 weeks"* (Lucie, 492). Participants' accounts suggested this meant they had to carefully consider and prioritise how they invested their time by 'weighing up' where they could have most influence:

> *"So again, it's just weighing up what's more important. Ultimately it feels like yes let's go and try and change the system! But actually how much time will that take away from the other clients that are waiting for psychology input every day?"* (Sadie, 597)

Subordinate theme three: Power "grapples"

The third subordinate theme for this section relates to difficulties using and managing power dynamics in the work. This related to their own identity as Clinical Psychologists, and in relation to others' use of power. Several participants spoke about the challenges of holding a relatively powerful position in a team whilst also trying to maintain positive relationships with colleagues,

> *"Sometimes it can feel like you're in a bit of an awkward position as a psychologist in a team I think. Because of the senior position you have and the leadership position you have but also because you want to be part of team in order to aid that communication. And get consultation happening and work well with clients. You need to be approachable for that part of it. So I always find that's quite a tricky balance."* (Sadie, 156)

The participants spoke about needing to navigate their own use of power carefully to maintain their relationships, whilst also using their position to empower others. There was a sense that the participants often tried to avoid being seen as powerful, *"anyone with Doctor before their name is seen as like some authority figure and I think for me like … through and through in all of my work, I'm always the psychologist. I'm always [Katie]. The human"* (Katie, 371), or as Rose explained: *"I like to demonstrate that I'm just normal"* (Rose, 427). Jess summarised this process of trying to hide or minimise the power she held to maintain good relationships with her team, highlighting the dilemma this could then lead to:

> *"There's been some grapples. [ ] Not physical grapples obviously [laughs]. Psychological grapples with power dynamics, and I think as a profession we're not seen as powerful because we don't want to be seen as powerful! You know you work hard not to have, all that I was describing around keeping up the good team relationships, but I think sometimes it can be to our detriment, that our voice isn't heard quite loud enough."* (Jess, 847)

As well as managing their own power, this subordinate theme also related to the ways in which participants spoke of power in other professionals and systems in their work. Their accounts suggested that they found others' positions and uses of power a challenge at times, with Rose expressing discomfort with where power lay in decision making in her service *"I just feel that psychiatry aren't the best placed to decide what psychological intervention we offer somebody"* (Rose, 293) and Lucie describing decisions being led by others, *"psychiatry at the top and then like we're a little bit lower"* (Lucie, 390). Sara indicated that the sense of hierarchy in her service could be a challenge, creating *"a lot of powerful others that try and take over the process."* (Sara, 555). Lucie summarised feeling a lack of power and authority in relation to others, describing this as *"like a solar system. Like you're just really little"* (Lucie, 588). This again highlights a sense of dilemma in relation to a sense of wanting or needing to hold some power, whist also being cautious and somewhat critical of the effect of power in systems.

3.3.3 Superordinate Theme Three: Impacts on self

This superordinate theme encompasses how participants spoke of their work having an impact on them at an individual level. Whist participants spoke more broadly about areas of challenge and reward from their work, which is to some extent encompassed in previously discussed themes, this theme captures ways in which they felt affected by their work at a more personal level. Two key subordinate themes emerged from this, relating to a sense of fulfilment from the work, and the emotional impact of the work.

Subordinate theme one: Fulfilment

Participants spoke of the ways in which they had found fulfilment from different aspects of their work. There was a clear sense that despite the challenges of their roles, participants also found rewards and felt valued: *"it's not smooth sailing... but knowing you are valued as a professional [merged] you know you're there for good reason"* (Jess, 320, 324). The participants' accounts highlighted clear feelings of pride from their work, with Lucie explaining *"I think there was just a sense of kind of pride almost. And like … it's a nice reminder that em, you know you're doing, you're kind of doing a good job"* (Lucie, 609). Sara spoke of feeling privileged in her clinical work and more widely, indicating a sense of fulfilment and pride: *"I just feel so… so, what's the word? I think privileged? I think that's the word, privileged, to be part of that journey. To be part of that, even in one incremental change in that person's life"* (Sara, 113). Ali also highlighted clear feelings of pride from her work:

"I think in some ways there was some pride. Some pride in the work we had delivered. [merged] Proud when other peers and professionals were coming up and saying wow that's really good. And kind of, could really appreciate the work that we were doing and kind of recognised the effort that everyone had put in. So that, that feels good too actually." (Ali, 245, 247)

The participants also suggested feelings of fulfilment from seeing positive changes in clients within their work, with Lucie recognising *"It feels really nice [merged] to kind of feel like I've put the, put the effort in with someone and it's paid off"* (Lucie, 178, 179) and Sadie similarly acknowledging positive feelings from her work with particular clients due to witnessing an improvement:

"It's really interesting and can be really rewarding. I think that's something about working in [that] part of the team. Although it can be really challenging em … you actually can see a really … good improvement." (Sadie, 740)

Sara similarly recognised the reward of seeing change in clients she worked with, reflecting a sense of inspiration from this: *"to go from that to… to kind of shifting... It's really, yes, really incredible really"* (Sara, 117).

Subordinate theme two: Emotional impact

Participants also spoke of the ways in which their work had impacted them at an emotional level, noting difficult feelings that their work could bring up. These feelings were linked to different aspects of their work and role. Some participants noted the emotional impact from their work with clients, with Ali describing uncomfortable feelings during her work with a particular client, *"it is, quite an unpleasant experience, sitting there with those physical symptoms of dread and anxiety and panic almost"* (Ali, 438). Lucie described noticing feelings of sadness in herself during a session in which a client spoke about difficult past experiences:

"As he went on I was just feeling quite sad just because of … it was just so kind of described, just like he was talking about anything really? Cos he's really quite like detached. Especially from sadness. Em… and… yes. I just remember at the point I felt quite sad really." (Lucie, 290)

Nat spoke of the feelings evoked from trying to manage a difficult supervisory relationship, highlighting feelings of sadness around this, *"it's just, it's just horrible! Just a horrible… experience to have that… you know I'm responsible for this person. And there's something that just isn't working! And, and, and that's really sad! That's really sad."* (Nat, 438). Sara spoke of the impact of providing support to her colleagues and of witnessing the emotions of others during a reflective practice session: *"It was almost like my body is like I need to react and you're not letting me cry [merged] So I had, you know, clearly had a*

visceral reaction to it" (Sara, 517), and suggested she found it difficult to distance herself from the emotions of others, *"there's a lot of sadness. It's hard to be separate from it"* (Sara, 699).

The participants' accounts also suggested that their work could generate self-doubt and self-criticism, with participants naming thoughts they had experienced in client sessions: *"questioning myself like 'Oh am I doing good enough here?'"* (Lucie, 235), *"It did make me doubt myself and my capability, my skill. And I was just sitting there usually thinking 'oh God I'm so shit!'"* (Ali, 338). Jess noted similar feelings of self-doubt, but instead in relation to her position in the service, describing a sense of obligation to her service and feelings of guilt about what she could offer; *"I almost feel apologetic for being part time"* (Jess, 431), and feeling pressure to prove her worth *"there's always been this kind of pressure of you know, are you doing good enough for earning your money?"* (Jess 891).

The participants also spoke of feelings evoked by wider pressures, with Katie describing feelings of despondency from feeling unable to influence change in the wider service, *"the kind of sense of helplessness and, and feeling a lot of that kind of systemic pressure and often feeling like what am I even doing? Like what progress am I even making with this?"* (Katie, 681). This was similarly echoed in Lucie's account when describing her feelings around some of the systemic barriers highlighted in the previous superordinate theme; *"I feel like, God, It'll just fall back into the way it is! Em, so like a little bit of despondence? And a little bit of, some frustration."* (Lucie, 455). Sadie spoke powerfully about how pressures in her wider service could evoke a range of strong feelings. Again, there was a clear sense that this strongly linked to the previous section and the impact of working "against the tide":

> *"Really helpless. Really like... what else can I do? So really, again, I suppose questioning myself? Em, thinking about, could I have done more? Feeling bad. Feeling guilty that I kind of prepared this lady for [service name] can help you. And then they said no! Em… angry, sometimes! And thinking you know like oh gosh this is, this is what it's like to work in the NHS!"* (Sadie, 535)

3.3.4 Superordinate Theme Four: Coping and sustaining factors

This superordinate theme encompasses various sources of coping and resilience that participants spoke about in their accounts of their work. The subordinate themes relate to factors which participants spoke about positively affecting their ability to cope with some of the challenges of their roles. There was a sense that participants were actively seeking out and making space for these factors i.e., had self-awareness that these areas were important to them. Some of the factors discussed are internal to the participants, yet there was also a clear sense of participants recognising that some areas of resilience were beyond their

control and something they had come to accept and adjust to, the acknowledgement of which seemed to serve a protective function in itself.

Subordinate theme one: Freedom to go "off piste"

Finding ways to work autonomously and work in ways which felt innovative and creative was evident in many of the participants' accounts as a protective and positive part of their work. There was a sense of participants actively seeking this out in their roles and carving space and time for projects or ideas which met this need. The title of this theme came from Katie's account of working creatively when offering a new service to another agency and the sense of enjoyment she got from being able to shape this project: *"we had quite a strict criteria from the commissioners about what we were supposed to be doing. But I sort of went off piste a bit because, because I could essentially! [Laughs] and it was just brilliant"* (Katie, 184). Jess also spoke about how much she valued working creatively and having freedom to make her own decisions, and reflected on this at the end of the interview:

> *"It kind of makes sense to me why I like certain bits more than others now [merged] It's the, em... parts you know where I'm allowed to do things that I like to do. Not just what, you know the job description says to do."* (Jess, 995, 996)

Rose spoke positively about having freedom to develop new initiative and pursue areas of interest; "this is kind of really new, I don't think it's been done before [merged] so I think, you know, that's a really nice initiative that we're kind of running with, and I feel quite passionate about it" (Rose, 93, 99). Sadie also highlighted autonomy as important to her and as offering her some protection against feeling restricted in her role:

> *"I'm grateful for the fact I'm not in a job where I have em … like my diary looked at or I don't have any stipulations in terms of you have to spend one day in this team, one day in this team. You have to see 8 clients a week or anything like that. So in that … in one sense I feel very grateful for that cos I feel that would be quite restrictive."* (Sadie, 606)

Although most participants spoke of ways they found this freedom in their roles, for some participants there was some divergence in their experience of this, in that they felt this was not met within their roles. Ali described a lack of freedom to implement interventions in the way she felt they were needed as a source of frustration and working hard to resist this: *"It wasn't what I was noticing clinically and there was a real pressure to kind of give in, but I stood my ground"* (Ali, 125). Lucie identified a lack of autonomy in her current role as a challenge and as a driver for her to begin some private therapy work: *"that is borne out of wanting something to contrast and balance it out. To feel like… I have a bit more autonomy"* (Lucie, 537). Although these differences existed in whether their roles met this need for autonomy, this was clearly important to the participants.

Subordinate theme two: Adjusting expectations

This subordinate theme encompassed the participants' descriptions of ways they had learned to adjust and adapt their expectations of themselves and their work to help cope with the challenges. Participants spoke about ways they showed self-compassion and tried to avoid putting too much pressure on themselves, with Jess describing an aim of *"going a bit easier or gentler with myself around the standards you're setting"* (Jess, 402), and Rose finding it helpful to remind herself *"you're fallible and things don't always go right [merged] and that's okay"* (Rose, 415, 417). Sara also spoke of having realistic expectations of herself as valuable and a strength: *"I think our bit of not doing is actually our strength. Because you know fixing, changing, offering a sticking plaster for big gaping wounds, we're not trying to do that"* (Sara, 71).

Sadie spoke of a process of finding reassurance from accepting some uncertainty around her role, reflecting the value for her of managing her expectations, *"that's what kind of comforts me. It's like, it's not like there's a right answer that I'm just trying to reach."* (Sadie, 620). Some of the participants also named supervision as important in helping them to *"reframe"* (Jess, 441) their expectations of themselves, with Katie explaining:

> *"My supervisor I think really helped me to think more broadly about… what I was doing and able to do. And the limits of what, also what we were able to do...[merged] often you know supervision was just quite grounding really."* (Katie, 260, 268).

Nat spoke of a process of accepting the limits to her control and focusing instead on areas where she could have more influence, by noticing and acknowledging frustrations but sometimes choosing not to invest her energy into this:

> *"I guess on the other hand like… letting it go a bit? Just like you know what … this … I need to go to that meeting. It's a very bizarre session in my day! But… where do I need to put my time and energy and, and do I need to put my energy into feeling confused and disorientated about this very strange meeting? Or can I use that bit of energy and put it into… something else a bit more productive? So just, just turn up… smile and get on with the meeting… and then, and then get on with the important things that I need to do."* (Nat, 648)

Similarly, participants recognised how factors beyond their control could affect their coping, with Ali finding it helpful to remind herself that her resilience was influenced by factors external to herself: *"Resilience doesn't always come from within. You know if, cos sometimes you're only as resilient as you know the environment around you or the context that you're kind of working in"* (Ali, 432).

Whilst this theme highlighted the sense of participants adjusting and accepting the limits to their influence, there is a sense of this conflicting with the way some participants identified self-doubt and pulls to 'prove' their worth in a previous theme (Emotional

impact). This suggests that the process of 'adjusting expectations' was ongoing, and perhaps more of established 'coping' approach for some participants than others.

Subordinate theme three: Celebrating the "small wins"

The final subordinate theme related to ways in which participants found value in attending to small changes or small successes within their work. This clearly relates to the previous subordinate theme, in that the participants' ability to manage their expectations allowed them to notice small changes which they could then celebrate. This theme title came from Katie and Rose, who both used the term *"small wins"* (Katie, 251; Rose, 357) when discussing ways of coping with challenges. This theme is framed by the way participants spoke of change as being a slow process in their services, across different areas of their work, with Jess remarking *"making change is slow and it, you know, my experience is it needs to be that kind of drip, drip, drip kind of change"* (Jess, 828). Lucie spoke of noticing small ways she could influence change when reflecting on her clinical work, and the sense of this being important for her to hold in mind:

> *"Maybe it's not so much what I'm even saying in the sessions with this guy? You know it's, it's the fact that I've just kept going you know? [merged] I think that's … kind of a nice reminder… em… at times that sometimes it's just, you know where I can make change. And sometimes it's just the little things actually."* (Lucie, 665, 670)

The participants' accounts indicated that they therefore attended to and celebrated what they perceived as positive outcomes in their work. Sara spoke of the value of noticing successes in her clinical work: *"the success is so difficult to get. So I think when we can have a success story, it's massive"* (Sara, 322). Ali highlighted how these moments allowed her to maintain hope: *"I think when I'm feeling more hopeless or… frustrated at work, that often comes to mind cos it helps kind of spur me on that actually… we can make a difference sometimes"* (Ali, 215), and withstand challenges:

> *"You can have another experience where actually that… really targets that idea of, you know what sometimes we can make a difference. And that I think for me, I can't underestimate that because that sustains me, I think, when I have those moments."* (Ali, 453).

CHAPTER FOUR: DISCUSSION

In this chapter, the results of the current study will be discussed and considered in relation to existing literature and relevant psychological theories. The strengths and limitations of this study will then be evaluated, with particular reference to methodological issues. The implications of the findings will be explored, followed by suggestions for future research. Finally, a concluding statement is given.

Prior to this, it is helpful to revisit the aims of the study and how these were addressed. Semi-structured interviews were analysed using IPA, to explore the following research questions:

- What are the experiences of those working as Clinical Psychologists in the NHS?
- How does this work present challenges or negatively impact individuals?
- How do people cope with these challenges?
- What are the positives of this work, and what facilitates this?

4.1 Summary of Results

The participants chose to discuss a range of experiences relating to their work, as summarised in the previous chapter. Despite variation in the content of specific experiences discussed, there were clear commonalities across the ways in which participants spoke about their work, particularly in relation to perceived challenges and rewards. This resulted in four superordinate themes:

- Relationships are “key”;
- Barriers and blocks: “up against” it;
- Impacts on self; and
- Coping and sustaining factors.

Each of these findings will now be explored and considered in relation to existing literature.

4.1.1 Key Finding One: Relationships are “key”

This theme encompassed the ways in which developing and maintaining relationships were central to the participants’ experiences of their work. The participants’ accounts suggested awareness of the importance of relationships through different aspects of their work, and an investment in working to form and maintain strong and authentic connections with people, whether co-worker or client. The significance of relationships at work is supported by existing literature around occupational wellbeing, with social connections with

others at work as a potential source of meaning and satisfaction (Blustein, 2001; Wrzesniewski & Dutton, 2001). In relation to those working in mental health, supportive relationships with colleagues can offer a source of reward (Collette, 2004; Jenkins & Elliot, 2004; Roncalli & Byrne, 2016; Rupert et al., 2015; Scarnera et al., 2009), and group cohesion or camaraderie in mental health teams may be protective against stress and burnout (Crawford et al., 2010; Freeman et al., 2011; Laslavia et al., 2009). This fits with the way work relationships were spoken of as *"anchors"* in the current study and depicted as a core foundation of the participants' work, providing stability and security. This mirrors a core concept of Attachment theory (Bowlby, 1988), which relates to infants developing a reliable and secure relationship with key attachment figures, allowing them to safely explore their world, take risks, whilst recognising that they can return to their safe and secure base if needed.

This idea of secure and strong relationships was also present in accounts of therapeutic relationships, i.e., relationships formed with clients through the course of therapeutic work. There is a wealth of literature around the importance of the therapeutic alliance as a key agent of change in therapy (Martin et al., 2000; Norcross, 2011), and so it is perhaps unsurprising that participants who spoke of therapeutic work were attuned to the relational aspects of this and worked hard to develop this *"bond".* Conceptualisations of the therapeutic bond suggest three key dimensions: working alliance, mutual affirmation, and empathic resonance (Orlinsky & Howard, 1987), which allow for the development of a strong relationship. These factors are shown to aid the process of therapy but may also have positive effects for the therapist, such as providing a source of satisfaction (Hunter, 2012). This study highlights that forming a genuine connection with clients could also be a source of reward for the participants and provide opportunities for mutual growth.

The participants' accounts also highlighted some of the challenges and tension present in their interpersonal relationships related to work. Participants presented some of the challenges of maintaining positive relationships with their co-workers. This fits with previous research suggesting difficult relationships with other professionals are a source of stress and burnout among those working in mental health (Edwards & Burnard, 2003; O'Connor et al., 2018), including between co-workers within services (Freeman et al., 2011; Scarnera et al., 2009). This may be related to the different backgrounds and values held by different professionals, which can create tensions within multidisciplinary teams (Murphy et al., 2013). Similarly, Onyett (1997) highlighted that individuals working in mental health teams can feel torn between team membership and their professional identity. This is consistent with the way participants spoke of valuing and working to maintain strong relationships with their team meaning they had to *"tread carefully"* when their views diverged from their co-workers'. This may also relate to ideas around power hierarchies in

organisations creating stress and tension (Van Thahn, 2016); overlapping with the *"power grapples"* spoken of by participants, which will be further discussed in the next section. Therapeutic relationships could also be a source of tension for participants, creating discomfort and unease. This is consistent with findings that challenging therapeutic relationships can be a source of stress in psychologists (Sciberras & Pilkington, 2018) and may contribute to burnout (Lee et al., 2020).

Importantly, the participants in this study seemed inherently aware of the importance of relationships in their work. Forming meaningful relationships, seeking belonging and social connection, is a fundamental psychological motivation (Baumeister & Leary, 1995; Maslow 1943; Ryan & Deci, 2000). It is therefore unsurprising that this is evident within work lives where team working and relationship forming is key. Additionally, Clinical Psychologists' training is grounded in attending to relationships. For example, training in models of varied psychological therapies which have a core foundation of forming strong therapeutic relationships, so increased awareness of this is expected. Focusing on relationships and attending to challenges and ruptures may be protective in maintaining these strong relationships. Their awareness and attention to this may allow them to work to develop a 'secure base' in relationships with both clients and colleagues. This may be especially important considering Clinical Psychologists' involvements in multiple relationships across multiple levels of a system (i.e., with clients, supervisors/supervisees, colleagues, and other professionals). Whilst this is not a novel finding, the extent to which relational aspects of work were spoken about by participants perhaps highlights the *"key"* importance of this area for this profession.

4.1.2 Key Finding Two: Barriers and blocks- "up against" it

This theme covered several areas which were spoken about as challenges or obstacles by participants. This included wider system barriers, feeling overstretched and conflicted in their roles, and navigating power dynamics. Issues relating to the wider organisation and systems were connected to the hierarchies within the participants' services, such as management, commissioning, NHS resourcing, and wider cultural and political policies. This seemed linked to participants identifying problems or challenges in their services and wider system but feeling powerless to influence or change these, or where changes were initially made, this feeling unsustainable and unsupported, leading them to feel stuck in a *"battle".*

The finding of stress emerging from service level challenges echoes recent research exploring ethical conflict in IAPT therapists (Proctor et al., 2020), highlighting clinicians experiences of feeling torn between organisational demands and client needs. The current study similarly suggests feelings of conflict can arise when psychologists are embedded in a

system that does not align with personal values i.e., the principles that guide and give meaning to our actions. The importance of alignment between personal values and those of an organisation is recognised in the theories of job satisfaction and burnout. For example, the Areas of Worklife model (Leiter & Maslach, 2003) highlights that a mismatch between individual values and those of a workplace can have a detrimental effect on engagement at work and contribute to burnout.

More specifically, low congruence between personal and workplace values and actions has been associated with increased burnout among mental health workers (Lamb & Cogan, 2016; Towey-Shift & Whittington, 2019; Vilardaga et al., 2011). This also fits with a very recent unpublished study exploring resilience in NHS Counselling and Clinical Psychologists, which highlighted participants' experiences of organisational pressures (Scevoli, 2020). Within this, resilience was suggested to be negatively impacted by a perceived misalignment between professional values (such as compassion and person-centred care) and organisational values of an increasingly market-led NHS.

A further relevant concept relating to the impact of working against one's core values is 'moral injury'. This term, which has become increasingly discussed in relation to healthcare workers during the Covid-19 pandemic, reflects a transgression of an individual's core moral belief system (Litz et al., 2009). As such, there is a growing recognition of the impact of external factors on individual wellbeing in relation to working in systems such as the NHS. The current study adds to the emerging literature emphasising the impact that organisational structures and barriers can have on professionals working in the NHS.

A further barrier related to participants' reports of feeling overstretched by competing demands in their roles. This is embedded in the context of the organisational barriers highlighted previously, such as the impact of staffing issues on workloads. The participants' accounts highlighted a lack of time to fulfil the different aspects of their role and spoke of needing to carefully prioritise their workload. This included some participants recognising that the areas they often sacrificed related to their professional development, such as reading around interventions or reflecting on learning. This is important when considering the value of such activities in maintaining up to date knowledge and practice safely, and the requirements of CPD for this profession set out by the HCPC.

The finding that participants felt overstretched at work is not an unsurprising discovery considering the recognised strain in NHS mental health services in the UK and limited resources in these services (Gilburt, 2015). This imbalance between demands and resources is evident in models of occupational stress such as the Job Demands-Resources Model (Demerouti et al., 2001), with chronic work overload suggested to be a core feature of burnout (Maslach & Leiter, 2016). This finding is consistent with previous literature highlighting excessive workload and lack of resources as key determinants of stress and

burnout among mental health workers (Hughes et al., 2016; McCormack et al., 2018; Morse et al., 2012; O'Connor et al., 2018; Onyett, 2011), with qualitative research further highlighting a sense of insecurity arising from high demands (Papadomarkaki & Lewis, 2008). The relevance of this has been further highlighted during recent months, with existing staff shortages and high workload among NHS staff exacerbated by the pressures of the pandemic and contributing to burnout (Gemine et al., 2021). The current study also highlights the potential detrimental impact of unachievable work demands on wellbeing and job satisfaction, providing a more focused and nuanced understanding of this experience within a specific population.

The participants' experiences of *"power grapples"* represented a struggle in the way they navigated power in their roles and teams. This could be considered in relation to the participants need to 'switch' between different positions of power in different parts of their roles. When working with clients and building relationships with teams, the participants worked hard to address and minimise power imbalances and take a 'non-expert' stance, which fits with the position of the discipline as an alternative to a more hierarchical medical-model in services (Onyett, 2007). Yet alongside this, Clinical Psychologists are placed as senior members of teams, recognised as skilled and autonomous with clear leadership qualities (BPS, 2019a), echoed in the ways participants spoke of feeling responsible to use their *"voice"* to empower others, address problems, and influence change.

This mirrors the dilemma that can occur between holding an 'expert' and 'not-knowing' approach for those working in mental health services (Cooke et al., 2019). This contradiction in power roles could be considered in relation to literature around role conflict, which occurs when individuals feel pulled between incompatible demands or status positions (Kahn et al., 1964). This role conflict can contribute to occupational stress (Demerouti et al., 2001), and has been associated with stress and burnout among psychological therapists (Lee et al., 2020). The current study highlights this as an area of challenge for Clinical Psychologists, which is a novel contribution to the literature. Future research exploring this sense of conflict may be useful to further understand and consider ways of managing this.

4.1.3 Key Finding Three: Impacts of the work

This theme related to the ways in which participants spoke of their work affecting them, in relation to the emotional impact and sense of fulfilment from the work. Although there was a sense of these areas relating to 'positive' or 'negative' impacts, these labels felt overly categorical and did not capture some of the nuances in the ways participants spoke of these experiences.

The sense of fulfilment inferred from participants' accounts related to feelings of accomplishment and pride from their work, and recognition of the value and meaning of their work. This may relate to intrinsic rewards noted in job satisfaction literature (Perkins & White, 2009). Within this theme, participants often referred to work with clients, consistent with previous findings that feeling able to 'make a difference' to clients and feel helpful and valued are motivating factors for staff working in mental health settings (Freeman, 2009; Wright, 2017). Similarly, Merriman (2017) found perceived self-efficacy as related to greater personal accomplishment among NHS mental health professionals, and Sciberras and Pilkington (2018) highlighted rewards including personal growth from therapeutic work among Psychologists in Malta.

The sense of fulfilment participants spoke of in the current study also appeared linked to seeing improvement or change in clients and witnessing their resilience, such as the sense of awe and pride expressed by some participants and seeing changes in clients as *"really incredible"*. This fits with literature around vicarious resilience (Hernández et al., 2007), in that seeing resilience and growth in clients can create meaning and growth for therapists. Previous studies focusing on trauma similarly highlight the sense of satisfaction and pride therapists may experience from seeing the value of their work (Michalchuk & Martin, 2018), and witnessing client success and resiliency (Barrington & Shakespeare-Finch, 2014). The current study highlights that work with clients may be an important source of meaning and reward within the varied roles of Clinical Psychologists. This appeared present even when the participants' accounts did not specifically relate to work focused on trauma. This is important when considering that direct therapy may be a progressively smaller part of the work of Clinical Psychologists given the increasingly varied nature of their work, yet may be a key source of reward and meaning.

The ways in which participants spoke of the emotional impact of their work highlighted how they also recognised feelings of sadness, anger, frustration, and anxiety within their work. Feelings of self-doubt and inadequacy were also noted, consistent with previous research among similar professionals (Bartoskova, 2017; Cushway & Tyler, 1996; Hannigan et al., 2004; Skovholt & Rønnestad, 2003; Theriault & Gazzola, 2005). This also echoes the notion of 'imposter syndrome' (Clance & Imes, 1978) in which high achieving individuals doubt their capabilities and feel fraudulent.

When participants spoke about the emotions arising from work with clients, this could also be considered in relation to psychodynamic approaches focusing on therapists' emotional responses to clients. For example, the concept of countertransference would suggest feelings the client expresses may trigger emotional reactions in the therapist through a process of identification (Gelso & Hayes, 2007). Emotive client work is an understandable source of challenge for professionals providing therapy, and this finding is consistent with

previous research (Sciberras & Pilkington, 2018). The ways some participants spoke of "visceral" emotional responses to some of their work with clients may relate to secondary traumatic stress (Figley, 1995). However, this was spoken about in the context of relational aspects of work with clients (e.g., feeling anxious or uneasy around certain clients) rather than in relation to trauma specific content of the work. Additionally, whilst participants spoke of these emotional impacts as powerful, they did not refer to deeper shifts in beliefs that are central to the concept of vicarious trauma (McCann & Pearlman, 1990). This perhaps indicates that these concepts may not reflect the experiences of the participants, which would align with the findings of a large-scale study of trainee Clinical Psychologists from Makadia et al. (2017). However, these particular concepts were not the focus of the current study, therefore had these experiences been explored in more depth further evidence may have emerged. It is also relevant that most participants chose to speak of aspects of their roles that were not focused solely on therapeutic work with clients, illustrating the varied nature of their roles.

The emotional impacts were also spoken of in relation to other aspects of their roles, such as feelings of hopelessness related to some of the wider systemic barriers described in the previous section. Similarly, McLellan (2018) highlighted that working in the NHS (described by one of their participants as a "traumatised system") negatively contributed to the wellbeing of Clinical and Counselling Psychologists. The way the participants in the current study described these challenges suggested these frustrations were more impactful for them than challenges in other aspects of their work. Participants expressed more frustration and distress around the organisational barriers they faced, compared to other aspects of their role such as direct work with clients. This illustrates the potential interplay between factors that may contribute to distress in roles such as Clinical Psychology that are embedded in stressed systems and services. Any experience of distress is therefore unlikely to be solely situated in one aspect of the work (i.e., between a therapist and client), and indicates that concepts such as vicarious trauma may have too narrow a focus to capture the 'full picture' for this profession. A broader understanding of distress arising from the work that captures the impact of wider interpersonal and organisational factors may therefore be useful.

4.1.4 Key Finding Four: Coping and sustaining factors

The way participants spoke of having freedom and flexibility in their roles as a positive is consistent with occupational wellbeing literature, with autonomy a core feature of the Job Characteristics Model (Hackman & Oldham, 1976) and Job Demands-Resources model (Demerouti et al., 2001). This is also consistent with research among mental health professionals which suggests job control and autonomy in relation to a perceived capacity to

make and influence decisions may generate feelings of accomplishment and be protective against burnout among mental health professionals (e.g., O'Connor et al., 2018; Rupert et al., 2015) whereas a lack of autonomy can contribute to stress (Lamb & Cogan, 2016; Steel et al., 2015).

Within this, participants also referred to working creatively and implementing innovative practice as positive aspects of their role. This aligns with the recognised skills of Clinical Psychologists in service development and leadership (BPS, 2007), and may be linked to participants feeling able to influence change and address problems creatively. Sodeke-Gregson et al. (2013) found time spent engaging in research and development as protective for trauma therapists, but there is limited attention to this area and the reasons for this in the existing literature. The findings of the current study suggest this autonomy and freedom to carve space for innovative work may be valuable to Clinical Psychologists and may counteract some of the areas which they feel they are less able to control and influence. Importantly, this is situated in the context of the previously discussed finding of the participants feeling *"spread too thin"* and recognition of needing to prioritise certain tasks or roles. It may be that one factor which contributes to this process is the extent to which an activity generates these feelings of autonomy and control.

The results also highlighted how participants had adjusted their expectations of themselves and their work, showing compassion to themselves and avoiding setting unrealistic standards of what they could achieve in their roles. This also incorporated a sense of acceptance and *"letting go"* of areas that were beyond their control, choosing to invest this energy elsewhere. This is reminiscent of principles of Acceptance and Commitment (ACT; Hayes et al., 2006) which includes core principles of acceptance or expansion to allow difficult thoughts and feelings to come and go, rather than struggling with them, and focusing on actions guided by personal values.

Importantly, this process of managing expectations feels somewhat contradictory to the context of training and qualifying as a Clinical Psychologist in the UK, a highly competitive process necessitating striving and high achievement. This may encourage unhelpfully high standards or 'maladaptive perfectionism' (Ashby et al., 2006) among trainees (Grice et al., 2018), which in turn can contribute to stress and burnout (Simpson et al., 2018). Additionally, overly high expectations of one's ability to influence change with clients may also be associated with distress and burnout (Skovholt & Rønnestad, 2003). Alternatively, holding more realistic expectations of oneself can be protective against burnout and may contribute to resilience (Bartoskova, 2017; Lamb & Cogan, 2016). The participants' acceptance of themselves as *"fallible"* humans suggests that they had found ways to manage their expectations of themselves to tolerate feelings of self-doubt highlighted in the previous section, and is perhaps suggestive of a process of adjustment. An exploration of

this potential process and how to nurture this among the profession would be an interesting area for further research.

The way participants spoke of being kinder towards themselves about their expectations, and acceptance of their weaknesses, also aligns with literature around self-compassion (Gilbert, 2009). This has been associated with greater wellbeing and resilience (e.g., Kotera et al., 2021) and may be protective against burnout (Beaumont et al., 2016).

An overlapping avenue of coping and resilience for participants centred on their acknowledgement and celebration of the *"small wins".* This related to paying conscious attention to success stories in their work, even if these seemed minor, and valuing smaller more achievable goals. Whilst this relates to some of the previous literature around managing expectations, this finding could also be considered in relation to vicarious resilience literature. This includes a recognition that actively attending to resilience and sharing positive stories from the work may in itself be beneficial (Silveira & Boyer, 2015; Clauss et al., 2018). This study highlights that this same process may be valuable in relation to the work of Clinical Psychologists more broadly, as this was not solely linked to therapy or trauma work. The notion of 'reasonable hope' (Weingarten, 2010) also feels relevant to the ways participants spoke about these experiences, which refers to "directing our attention to what is within reach" (Weingarten, 2010, p.7), and frames hope as a verb, something we actively do and seek. The participants' ability to notice and attend to these 'reasonable' goals, and celebrate positives when they occurred, seemed to contribute to their coping with the challenges of their work.

Notably, despite the challenges, many of the participants at some point during the interview clarified that they still enjoyed or even loved their job and expressed a sense of privilege to be working as a Clinical Psychologist. There was a sense that they wanted to share this to ensure this was captured, even when they spoke of largely difficult experiences, perhaps highlighting the overall sense of value they found in their work.

4.1.5 Conceptualising the Findings

Bronfenbrenner's ecological systems theory

The findings from this study reflect a range of ways in which Clinical Psychologists may be affected by their work. Bronfenbrenner's (1979) ecological systems theory offers a useful framework to understand these findings. As described in Chapter One, this model is a way to understand the many interacting systems which may influence an individual. This model recognises that individuals are affected not only by their immediate environments, but by relationships across multiple levels. Considering the findings of the current study in

relation to these different levels, it is possible to map the ways participants described influences in their work roles onto this model.

The participants recognition of the importance of their direct relationships with other individuals, such as service users and colleagues, could be represented in the microsystem, which concerns immediate environments and direct interactions. Additionally, the mesosystem, which encompasses interactions between two microsystems, is captured in the ways participants described interacting environments, such as their experiences of working collaboratively with different team members, or providing and receiving supervision around their work. Some of the issues and themes identified at a wider service level or within commissioning and resourcing may be situated within the exosystem, with an indirect but clearly important influence on the individual participants. Finally, the macrosystem is represented in the wider socio-political context such as the impact of ongoing discussions around NHS funding, media coverage and narratives of the NHS, and the impact of the Covid-19 pandemic.

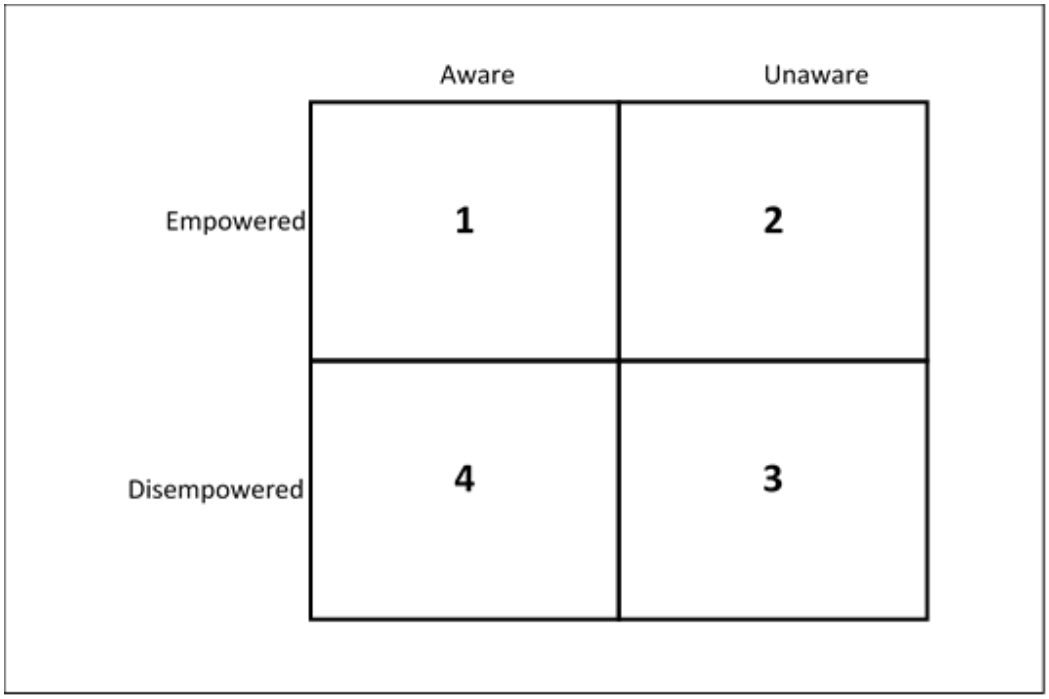
Conceptualising the results within this model highlights the systemic nature of the Clinical Psychologist role and illustrates the impact that changes or events within one system may have on others, and ultimately on the individual. Again, this helps to illustrate the importance of recognising the many ways in which interacting systems could contribute to the stresses and rewards of this role.

Weingarten's model of 'witnessing'

A key overarching finding from this study relates to similarities in the ways different aspects of work provided a source of reward or challenge. This seemed to relate to areas in which the participants felt able to impact change (e.g., in individual client work, or in implementing new initiatives and innovative practice) versus areas they felt less able to influence (such as the wider system). This echoes a model of 'witnessing' proposed by Weingarten (2000, 2004), which was developed in relation to trauma work but may also help to conceptualise the different ways individuals working with different sources of stress and strain are affected by their work.

This model consists of four witnessing positions, which vary according to the awareness and empowerment of the witness (e.g., the individual therapist) in relation to trauma/violence. In position one, the witness is aware of the implication of the violent act on others and is empowered to be able to effectively act on this. In position two, the witness holds power or influence but is unaware of the implications of the act on the victim. In position three, the witness has neither awareness nor power to act. In position four, the witness has awareness but is powerless or unable to act on this. A visual representation of this model is shown in Figure 4.

Figure 4. Visual representation of Weingarten's four witnessing positions.



Note. Reprinted from "Witnessing, wonder, and hope", by K. Weingarten, 2000, Family Process, 39(4), 389–402. Copyright 2000 by FPI Inc. Adapted with permission.

Weingarten's model draws attention to the potential importance of awareness and ability to act in mediating how people may be affected by trauma work. She proposes that those who often find themselves in position four are most vulnerable to vicarious trauma, and suggests that developing awareness of these positions can increase the opportunity to change position and in turn mediate the impact of the work.

Although this model has its roots in theory and research around trauma and violence, considering this in relation to the wider experiences of professionals including Clinical Psychologists may be useful in understanding how and why people may be affected to different degrees by the challenges they face, such as the sense of frustration expressed by participants around service level issues which they were aware of but felt powerless to influence. This seems fittingly summarised in the below extract from Lucie, taken from towards the end of her interview when she was reflecting on the areas she had chosen to speak about:

> *"With the individual patient work it felt like a case of coming up against resistance to change but persevering and through the therapeutic relationship coming out the other side somewhat? Em… whereas I suppose on a more systemic level with the team we come up against change but they're not necessarily things that can be… fixed or kind of remedied by just putting the time in. Em or trying to build relation, a relationship or persevering but almost has to be… kind of more practical solutions? Em… and maybe*

that's why one is kind of more successful that the other because you're kind of more powerless with the practical solutions I think? Em… I can't like just magic away some of my workload [laughs] or kind of necessarily influence kind of the big people at the top who hold budgets. [merged] I think you just feel like there's too many em walls above you to kind of… influence things on a big level? But I can go and see a patient every week who doesn't want to see me! [laughs] you know that's something I can do! Em… So I, I think it's kind of what's within your remit almost? Em… and yes it's easier to create change with one person than a whole organisation." (Lucie, 572, 590)

4.2 Strengths and Limitations

4.2.1 Research Focus

This study addressed an important gap in research and has provided an in-depth qualitative exploration of Clinical Psychologists' experiences of their work, allowing for an understanding of both the rewards and challenges of this, and capturing the different aspects and levels of work in this role.

This reflects a novel contribution to the literature around the workplace experiences and wellbeing of Clinical Psychologists. The personal accounts shared by the participants add context and depth to findings from survey-based research (e.g., Summers et al., 2020) and has potentially useful implications for the profession. As described in Chapter three, Clinical Psychologists were consulted during the development of the research through a brainstorming event in which they were encouraged to share their views and ideas. This suggests the research focus has value and meaning for the individuals it concerns.

4.2.2 Recruitment and Sample

The recruitment method chosen allowed for a specific group of participants to be identified whilst allowing for geographical variation, through advertising the study on a social media group. Through using this approach there is a risk of selection bias in that the individuals who chose to take part in the study may have been motivated by strong feelings about the profession, either negative or positive. The relatively broad nature of the advert was an attempt to mediate this, and when participants were asked about their motivation to take part most participants spoke of doing this as a way of contributing to trainee research aims.

In relation to Smith et al.'s (2009) ideas around homogeneity, although the current sample was homogenous in that they all worked as Clinical Psychologists in the NHS and met the inclusion criteria, there was variation in characteristics such as the services they

worked in and their level of experience, as well as in the experiences they chose to speak about. Nevertheless, this was central to the study aims, as had the focus been on a specific work area this would have framed the results within a single speciality or context. There were clear similarities and convergent themes across the participants and the ways they spoke of their work, despite their different work settings. This suggests the recruitment and sampling method was appropriate for the study aims.

Although there was some demographic diversity among the sample, such as age, the sample lacked diversity in other areas. For example, no male participants took part, all participants identified as heterosexual, and seven of the eight participants were White. Therefore, there may be differences in the experiences of individuals not captured within this study, such as male Clinical Psychologists. Additionally, this work cannot tell us how additional pressures, such as the experience of racism, may impact on Clinical Psychologists at work. Further research would be needed to consider whether the themes that emerged from this study resonate more widely.

A further point relating to demographics concerns the type of information collected. It may have been useful to collect information in line with existing quantitative evidence around job satisfaction and wellbeing at work, such as quality and quantity of supervision, and relationships with management. This may have further contextualised the sample and added to existing evidence around factors which may be particularly relevant to satisfaction and wellbeing at work.

4.2.3 Interviews

Semi-structured interviews were used in line with guidance from Smith et al. (2009). Whilst these allowed for a guided conversation between the researcher and participant, the use of a topic guide containing questions and prompts may have inevitably shaped participant responses. Furthermore, the similarities between myself and the participants may have also influenced the interviews, which was evident on occasions when participants explicitly drew attention to my role as a trainee. Even when participants did not name this, they were aware of my position as a trainee and may have felt uncomfortable discussing particularly difficult experiences with me to avoid presenting a negative image of the career I am due to enter. Although I did not have existing relationships with any of the participants, it is plausible that we may have had mutual connections or may come into contact future within a professional remit. Again, this could have led to participants self-monitoring and avoiding discussing certain experiences. This may have been more of an issue had the research focused on specific experiences (such as vicarious trauma), however may have been less of an issue considering the research aims were not specifically focused on sensitive or difficult experiences.

A further possible issue relating to the interview process relates to how participants' job roles may have shaped how they used this space. Some participants noted finding the space helpful in allowing them to reflect on their experiences, and whilst this may have allowed for openness and detail in their accounts, they may have been more likely to discuss challenges or difficulties in their work, akin to how they might use clinical supervision or reflective practice. This perhaps accounts for the sense of some participants wanting to clarify that they enjoyed their jobs at the end of the interview, concerned they had been overly negative.

4.2.4 Quality Checks

A number of quality checks were used throughout this research, as detailed in Chapter two. I maintained a reflexive stance throughout the research, keeping a reflexive journal and considering my own positioning in relation to the research allowing me to 'bracket' some of my presuppositions. Despite this, the double hermeneutic of IPA inherently means my views and feelings will have impacted the analytic process (Smith et al., 2009), and a researcher with a different background, views and experience may have found differing results. To try to manage this, individual participant themes were discussed with the research supervisor and within a peer discussion group, and through a detailed validation session with a peer at a similar stage of IPA research. This allowed me to consider different perspectives on the data and clarify themes, and encouraged me to scrutinise my interpretations to ensure there was a clear link back to the original transcript.

The group analysis process was further aided by guidance and reflection with the research supervisor and a peer. Photographs and documents were retained throughout this process to allow for a transparent trail of the process of analysis. The pen portraits and extracts presented in the results chapter also provide this transparency by providing important contextual information and referencing individual themes. The credibility of themes could have been further enhanced by checking these with participants and seeking feedback. However, the use of feedback from peers and research supervisor was thorough and allowed for alternative perspectives and meanings to be explored (Dempster, 2011).

4.2.5 The Impact of the Covid-19 Pandemic

It is important to acknowledge the potential impact of the Covid-19 pandemic on this research. The participants in this study were recruited and interviewed between July and October 2020. At this time many had adapted their ways of working, such as working remotely, in line with social distancing guidelines. This did not apply to all participants as some worked in settings where this was not possible, however, their experiences at work

will have undoubtedly been influenced by the strains of the pandemic, in addition to ways in which this may have affected their personal lives. Direct references to the pandemic were less common than I anticipated in the interviews, however, this context cannot be overlooked and may have influenced the results in ways I am not aware of. For example, the sense of relationships being core to participants may reflect the restrictions on social contact at this time and increased attention to this.

4.3 Implications

For the Clinical Psychologists who took part in this study, multiple avenues of stress and reward were present, mirroring the varied nature of this role. Previous research has generally focused on one side of this coin, either the challenge or positives, yet this research highlighted these areas as interwoven, such as the benefits and strains of relationships formed through their work. By taking a broader perspective, this study has allowed for valuable insights into the working life of a profession which is under increasing pressure in the current NHS (BPS, 2019b), and contributed to the understanding of how such professionals cope and even thrive in challenging contexts.

A key implication relates to the understanding of resilience among mental health professionals, particularly in relation to working within a stretched system such as the NHS which was a source of frustration for participants. This highlights that resilience goes beyond individual responsibility, as emphasised by one participant in this study, *"resilience doesn't always come from within".* As stressed by Scevoli (2020), the value alignment between individuals and organisations is key, but when individual expectations of an organisation (based on their purported values) are not met they may feel misled, or experience this as a moral injury.

Interventions solely focused on the individual (e.g., self-care) may further perpetuate unhelpful individualistic notions of distress (Reynolds, 2011). The current spotlight on NHS staff wellbeing due to the impact of the Covid-19 pandemic offers an opportunity to shift this narrative, and there is a growing public recognition that the responsibility to do this does not lie only with individuals (Health and Social Care Committee, 2021). Increasing awareness of this may empower clinicians to recognise this, rather than viewing issues of 'burnout' or 'resilience' as concerns located solely in themselves.

Although individualist self-care practices alone may have limited benefit, the current study suggests there may be value in professionals utilising approaches that acknowledge and encourage acceptance, managing their expectations, focusing on areas within their control and recognising the importance of values, such as ACT (Lamb & Cogan, 2016). There is emerging evidence of the value of ACT for staff working in organisations such as the NHS (e.g., Brown et al., 2020), and increasing workplace initiatives based on this

approach may provide staff with psychological skills to tolerate some of the challenges of their work.

Encouraging reflection and recognition of positives and successes in the work may also be useful in allowing individuals to see the meaning and value in their work, enact 'reasonable hope', and create a buffer against some of the challenges (Clauss et al., 2018; Silveira & Boyer, 2015). Having time to do this may be a more practical challenge, so allowing space within existing practices (e.g., within reflective practice sessions or peer supervision) to talk about these successes is useful. Reflective questions such as those suggested by Mann (2005; Appendix 13) that allow for a recognition of distress resulting from systemic issues as well as individual client work may be particularly helpful in aiding this.

Underpinning these areas, the finding from the current study that relationships are *"key"* illustrates the importance of interpersonal relationships for Clinical Psychologists, in relation to other professionals, managers, supervisors, clients and others. Finding ways to allow and foster strong relationships that can withstand challenges may therefore be particularly important to this group; for example, in relation to teams may relate to protecting time for staff to come together, to reflect together and instil hope in each other.

4.4 Future Research

The findings of the current study highlight several potential areas for further research. The experiences of individuals working as Clinical Psychologists in the NHS are clearly complex and multifaceted. This study provides a glimpse into these experiences, but further research will be crucial to explore this further. In particular, research with larger and more diverse samples would help to extend the transferability of these findings.

It may be useful to consider a more specific focus on some of the findings of this study in future. For example, the ways participants spoke of navigating power and conflicting sense of role identity was highlighted but not explored in depth. Research aimed at exploring these experiences among Clinical Psychologists may allow for a greater understanding of how these different roles are navigated. Similarly, the process of adjusting expectations may be an interesting focus for further research. This was something that participants identified as protective, and understanding more about how this process occurs may be useful in building on this. Additionally, capturing the experiences of a more diverse range of participants will be useful.

4.5 Conclusion

This study aimed to develop an insight into the experiences of Clinical Psychologists working in the NHS, to understand the meaning given to different aspects of this work including the perceived challenges and rewards. The use of IPA allowed for a detailed analysis of individual accounts and patterns across the group, resulting in four key superordinate themes. This research was motivated by a lack of qualitative work in this area. A further key motivator was the recognition that focusing too narrowly on one aspect, such as therapeutic input, may mean other aspects of this work that may have an impact, such as organisational factors, are overlooked. Alongside this, there is a clear value of understanding the experiences of staff working in systems such as the NHS at a time when staff wellbeing is an increasing concern (BPS, 2021).

The findings of this study highlight the multifaceted nature of working as a Clinical Psychologist in the NHS, and the many sources of challenge and reward. Importantly, these factors may often overlap and interact. The organisational context in which they work shaped the participants' experiences; they noted the challenges of working in a stretched system and resulting feelings of powerlessness and frustration. Other aspects of their work such as relationships formed with clients and colleagues provided a source of containment and reward but could also contribute to tension and required careful nurturing. This was also related to the ways power impacted the participants' work and relationships, and the challenge of occupying multiple roles in relation to power. Several areas contributed to the emotional impact of working in a challenging role, including emotions evoked by organisational challenges as well as working with clients and colleagues. The participants spoke of how they coped with some of these challenges and found enjoyment and fulfilment from their work, including finding ways to ensure they could pursue areas of interest and feeling they had the autonomy to do this. This appeared related to feeling able to influence change in these areas. Alongside this, they described adjusting their expectations and learning to notice and appreciate small successes as sustaining them in their work.

For the participants in this study, it seems that a constant *"juggling act"* was needed to balance the different demands and challenges of their work, whilst also making space for areas of passion, interest, and fulfilment. The participants' reflections of enjoying and valuing their roles, seeing their position as a *"privilege",* suggests they were generally able to find this balance successfully, although clearly this was not an easy endeavour and required effort and sacrifice.

The insights offered by this study come at a time where there is a greater than ever focus on the wellbeing of NHS workers, with the pandemic illuminating fundamental issues in the workforce such as pervasive staff shortages as key contributors to staff stress (Health and Social Care Committee, 2021). Clinical Psychologists are well placed to support the

growing needs of an NHS workforce under stress, but also exist within and are affected by these same pressures. Therefore, the findings offered by this study in relation to the experiences and coping factors described, whilst only a ‘snapshot’, offers a valuable and important insight into the experiences of this profession.

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APPENDICES

Appendix 1. Ideas Generated During a DCP Event (14.05.2019)

Ideas and questions *(Attendees were asked to generate areas of interest for research)*
Not looking at the relationship between psychological distress of client and distress of therapist – extent of similarity, mediating factors- processing of distress in therapist to therapy ?projective identification Issues at interpersonal client/therapist level
Self-care- what is most effective? Organisational / self -main characteristics? What are the barriers to accessing help – why don't we mend our own fence first? Is it harder in some areas because of the nature of the client group- is there an effect if the client Is more similar to yourself? What model is the most damaging to the therapist? Which is the best management style for promoting resilience?
Does your attachment style at work medicate vicarious resilience? Specific qualities within supervisor relationship or other key relationships? More research into positive growth from working with trauma and increased resilience The fluidity of tolerance of working with stress – fluidity of protective factors and engaging with different things at different times Experiences of disclosing distress/ mental health problems Importance of taking a break/step back Perceptions of how work will impact us vs. actual impact
Why aren't there more psychologists in socio/political contexts? How acceptable is personal distress in our services? E.g. external supervision is difficult to obtain How vulnerable are we allowed to be with supervisors/ employers etc Why doesn't clinical training require personal therapy? When is the distress the clients and when is it ours?
Impact of terror attacks on staff working in trauma services- more/less traumatised? Psychology safety in NHS organisations related to burnout/ compassion fatigue levels in staff. Coping strategies? Staff surveys – differences in trusts. Sickness rates? Systems around the clinician e.g. partners/family
The impact of organisational flux and uncertainty – impacts on the individual workers capacity to manage/cope with trauma-related clinical work The impact of the clinicians attachment style on their experience of doing trauma related work
Can you influence systemic change? – How? How do we measure change – what is it/ how do we define it? Are people interested in the psychological impact of our work? Why is there a lack of research in the area? Why do people leave their jobs – what factors affect this? E.g. relationship between sickness rates/ turnover of staff/ burnout and vicarious trauma? How do we capitalise on post-traumatic growth? How do we know that we are making a difference or achieving our goals as psychologists – being valued by others/ valuing ourselves? Change that seems to happen at the 'top' – how are the decisions made? How do we influence decisions? How do we challenge the barriers that limit our effectiveness to change systems? What are the enactments playing out in systems and organisations that mirror our clients stories/narratives? Workplaces / Academic institutions
How do we operationalise sharing experiences? How do we develop cultures of looking after ourselves – how we do establish wellbeing? Client experiences of therapist self-disclosure? Use of therapeutic communities? Personality traits linked to self-disclosure? What mediates the impact of self-disclosure? Psychology as 'fixers' – balance between role of psychologist and impact of work How to develop resilience in training – can resilience be taught?
Exploring the inter-relation between vicarious trauma and vicarious resilience What is a 'good-enough' organisation to work in? What does a 'good-enough' therapist look like/ be? How can we minimise the impact our work/ organisation has on us? What is resilience? Common factors that help with self-care? Differences in how a therapist a client may understand the concepts of trauma and resilience What are the factors or understanding of why therapists are less likely to follow their own principles of self-care?

Appendix 2. Advertisement

UNIVERSITY OF LEEDS

Research study: Understanding clinical psychologists' experiences of their work: An IPA Study.

My name is Asha Greaves and I am a trainee clinical psychologist studying for a Doctorate in Clinical Psychology at the University of Leeds.

I am interested in exploring the experiences of qualified clinical psychologists who trained and work in the UK and currently work as a clinical psychologist within the NHS. This study will use a qualitative design to understand your experiences of the different aspects of your work, such as therapy, supervision, consultancy and working within teams.

The study would involve you taking part in an interview with me for around an hour. You can choose whether you would prefer to do this over telephone or video-call. Your responses will be kept anonymous and confidential.

If you are interested in taking part or would like more information, please contact me via email at: **umamg@leeds.ac.uk**

Thank you for your time.
Asha Greaves

Appendix 3. Participant Information Sheet

Leeds Institute of Health Sciences: Faculty of Medicine and Health

UNIVERSITY OF LEEDS

Participant Information Sheet, Version 5: 19.06.2020

Title of Project: Understanding clinical psychologists' experiences of their work: An IPA Study.

Invitation to take part:
You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the project?
The purpose of the study is to explore what it is like working as a clinical psychologist in the UK. We are interested in knowing how different aspects of the work might affect people, such as direct work with service users, indirect work such as consultation and supervision, and working within organisations. We are keen to know what people's experiences are and how they make sense of these experiences.

Ethical approval for this project has been sought from the DClin Research Ethics Committee at the University of Leeds (**Reference:** MREC 19-077).

Why have I been chosen?
You have been approached as you have shown initial interest in the project. Participants are required to identify as a clinical psychologist (at least one year qualified) currently working within the NHS, who are willing to talk about and reflect on their experiences of their work.

Do I have to take part?
No. Taking part in the research is entirely voluntary and you can withdraw participation at any time during the interview, or up to two weeks following the interview. You do not have to give a reason. To withdraw from the project, please contact the lead researcher using the details at the end of this form. Unfortunately if you wish to withdraw later than 2 weeks after the interview, this may not be possible as data analysis is likely to have begun.

What do I have to do?
If you would like to take part, you will be asked to participate in an interview exploring your experiences, lasting for between 45 – 90 minutes. Interviews will take place via an online platform such as Skype or Microsoft Teams, and can be just audio or audio and video, depending on your preference. The interviews will be audio-recorded. I will then transcribe the interviews and consider any patterns or trends that emerge.

What are the possible disadvantages and risks of taking part?
There are no anticipated risks in taking part in the study. However, we recognise that the interviews may involve discussing difficult or challenges parts of your work which may lead to distress. It is up to you what you share, and you will be under no obligation to discuss anything you do not feel comfortable sharing. However, if you do find yourself becoming distressed the researcher will follow your lead with what you need at this time. You are welcome to take a break or pause the interview, or to continue if you would prefer to at a pace that feels comfortable to you. We appreciate that you may be aware of sources of further support should you want to access this (e.g. your GP, personal therapy, workplace occupational health) but if you would like any further advice or signposting to services the researcher will be happy to support you with this.

What are the possible benefits of taking part?
There are no direct benefits to taking part in the study. However, having space to reflect on and share your experiences openly may be a helpful and potentially validating experience. Additionally, it is hoped that this research will be published and disseminated, which may allow for a wider understanding of how clinical psychologists experience their work.

What will happen to my personal information?
Any direct identifiable information (such as your name or place of work) discussed during the interviews will be removed from the transcripts. This will also apply to any identifiable information about third parties discussed, such as service users or colleagues. The researcher will take this responsibility; however, you may also wish to refrain from using any details which may clearly identify another person such as any unique characteristics.

All personal contact information that we collect about you during the research will be kept strictly confidential and will stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications. Some aspects of your data may however be relevant for situating your participation in the research, such as a broad overview of the type of area you work in, although this will be kept to a minimum.

There is an exception to the confidentiality around the interviews. If you state something which makes the researcher concerned that you or someone else is at significant risk of harm, this information will need to be shared. The researcher will discuss with you how this will be managed wherever possible, such as who will need to be informed and how information will be shared.

Please read the attached "**Research Participant Privacy Notice**" regarding the use of personal data for research.

How will my data be stored?
All recordings, transcriptions and any relevant documents will be password protected and securely stored on a University of Leeds secure network. Only the researchers conducting the study will have access to this data.

Quotes from the interviews may be used in the written report, or future publications, but every effort will be made to anonymise these. Interview recordings will be destroyed after transcription has taken place. Anonymised data from this project will be stored electronically on the university's secure server for 3 years.

What will happen to the results of the research project?
The results of the project will form part of my thesis, and may be submitted for publication in an academic journal.

Contact details
If you would like to take part or have any questions, please contact the lead researcher, **Asha Greaves**, using the below details.

Lead researcher:
Asha Greaves
Trainee Clinical Psychologist
Leeds Institute of Health Sciences
University of Leeds
Clarendon Way
Leeds
LS2 9NL
Email: umamg@leeds.ac.uk

Supervised by:
Dr Fiona Thorne
Clinical and Academic Tutor
Leeds Institute of Health Sciences
University of Leeds
Clarendon Way
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Tel: +44(0)113 343 8343

Thank you for taking the time to read through this information sheet.

Appendix 4. Research Participant Privacy Notice

RESEARCH PARTICIPANT PRIVACY NOTICE

Purpose of this Notice

This Notice explains how and why the University uses personal data for research; what individual rights are afforded under the Data Protection Act 2018 (DPA) and who to contact with any queries or concerns.

All research projects are different. This information is intended to supplement the specific information you will have been provided with when asked to participate in one of our research projects. The project specify information will provide details on how and why we will process your personal data, who will have access to it, any automated decision-making that affects you and for how long we will retain your personal data.

Why do we process personal data?

As a publically funded organisation we undertake scientific research which is in the public interest. The DPA requires us to have a legal basis for this processing; we rely upon "the performance of a task carried out in the public interest" as our lawful basis for processing personal data, and on "archiving in the public interest, scientific or historical research purposes, or statistical purposes" as our additional lawful basis for processing special category personal data (that which reveals racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, genetic or biometric data, and data concerning health, sex life or sexual orientation).

How do we follow data protection principles?

- We have lawful bases for processing personal and special category data.
- Data are used fairly and transparently; we will make it clear to individuals what their data will be used for, how it will be handled and what their rights are.
- We only collect and use personal data for our research, for research in the public interest, or to support the work of our organisation.
- We only collect the minimum amount of personal data which we need for our purposes.
- We take steps to ensure that the personal data we hold is accurate.
- We keep your personal data in an identifiable format for the minimum time required.
- We take steps to ensure that your data is held securely.
- We keep a record of our processing activities.

What do we do with personal data?

Research data can be a very valuable resource for improving public services and our understanding of the societies we live in. One way we can get the most benefit from this work is to make the data available, usually when the research has finished, to other researchers. Sometimes these researchers will be based outside the European Union. We will only ever share research data with organisations that can guarantee to store it securely. We will never sell your personal data, and any data shared cannot be used to contact individuals.

The project specific information will include more detail about how your data will be used.

Your rights as a data subject

Because we use personals data to support scientific research on the public interest, individuals participating in research do not have the same rights regarding their personal data as they would in other situations. This means that the following rights are limited for individuals who participate, or have participated in, a research project:

- The right to access the data we hold about you.
- The right to rectify the data we hold about you.
- The right to have the data we hold about you erased.

- The right to restrict how we process your data.
- The right to data portability.
- The right to object to us processing the data we hold about you.

Data security

We have put in place security measures to prevent your personal data from being accidentally lost, used or accessed in an unauthorised way and will notify you and any applicable regulator of a suspected breach where we are legally required to do so.

Retention periods

We will only retain your identifiable personal information for as long as necessary to fulfil the purposes we collected it for; we may then retain your data in anonymised or pseudonymised format.

To determine the appropriate retention period for personal data we consider the amount, nature, and sensitivity of the personal data, the potential risk of harm from unauthorised use or disclosure, the purposes for which we process your personal data and whether we can achieve those purposes through other means, and the applicable legal requirements.

Additional notices and guidance/policies

The University has also published separate policies and guidance which may be applicable to you in addition to other privacy notices:

Current staff privacy notice
Current students privacy notice

The Research and Innovation Service website has other relevant policies and guidance.

Communication

In the first instance please contact the researcher who your initial contact was with.
You may also contact the Data Protection Officer for further information (see contact details below).

Please see the Information Commissioner's website for further information on the law.

You have a right to complain to the Information Commissioner's Office (ICO) about the way in which we process your personal data. Please see the ICO's website.

Concerns and contact details

If you have any concerns with regard to the way your personal data is being processed or have a query with regard to this Notice, please contact our Data Protection Officer (Alice Temple: A.C.Temple@leeds.ac.uk).

Our general postal address is University of Leeds, Leeds LS2 9JT, UK.

Our postal address for data protection issues is University of Leeds Secretariat, Room 11.72 EC Stoner Building, Leeds, LS2 9JT.

Our telephone number is +44 (0)113 2431751.

Our data controller registration number provided by the Information Commissioner's Office is Z553814X.

This notice was last updated on 20 February 2019.

Appendix 5. Consent Form

Consent form, Version 4: 31.03.2020

UNIVERSITY OF LEEDS

Consent to take part in: **Understanding clinical psychologists' experiences of their work: An IPA Study.**	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet (Version 4, dated 31.03.2020) explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time during the interviews and up to two weeks following the interviews without giving any reason and without there being any negative consequences. Any data collected up until the point of withdrawal will be deleted in full. In addition, should I not wish to answer any particular question or questions, I am free to decline. I know that I can contact the researcher, Asha Greaves (umamg@leeds.ac.uk) to indicate my withdrawal from the project.	
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and steps will be taken to ensure I am not identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential unless there is risk to myself or others in which case information may need to be shared.	
I agree for the data collected from me to be stored and used in relevant future research in an anonymised form. I agree for the data I provide to be archived on the University of Leeds secure drive for 3 years following my participation.	
I understand that other genuine researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date	

Please complete this form electronically if possible, typing directly into the form and using an electronic signature. Alternatively, please print, complete, and scan the form.

Once completed please return this form via email to umamg@leeds.ac.uk

Appendix 6. Confirmation of Ethical Approval

From: Rachel De Souza [Medicine] <R.E.DeSouza@leeds.ac.uk> **On Behalf Of** Medicine and Health Univ Ethics Review
Sent: 08 July 2020 14:29
To: Asha Greaves <umamg@leeds.ac.uk>
Cc: Fiona Thorne <F.M.Thorne@leeds.ac.uk>; Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>
Subject: RE: MREC 19-077 Study Approval

Dear Asha

MREC 19-077 - Understanding clinical psychologists' experiences of their work: An IPA Study

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and on behalf of the Chair, I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx or contact the Research Ethics Administrator for further information (FMHUniEthics@leeds.ac.uk) if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Best wishes
Rachel
On behalf of Dr Naomi Quinton, co-Chair, SoMREC

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Rachel de Souza, Lead Research Ethics & Governance Administrator, The Secretariat, Room 9.29, Level 9, Worsley Building, Clarendon Way, University of Leeds, LS2 9NL, Tel: 0113 3431642, r.e.desouza@leeds.ac.uk
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Appendix 7. Topic Guide

Interview Schedule, Version 7: 02.06.20

Research study: Understanding clinical psychologists' experiences of their work: An IPA Study.

Introduction

Thank you for agreeing to participate in this study and taking the time to talk to me today. I'd just like to firstly go through the information sheet and consent form you have returned to me and check that you still want to take part.

[Review consent form – remind participant of confidentiality, ethics, right to withdraw/stop the interview]

Do you have any questions? [Begin recording]

As you know, I am interested in talking to clinical psychologists about their experiences of their work. I'd like to explore your experiences and how you have made sense of them. I will ask some questions during the interview but I would like this to be guided by you – I am interested in what you want to say and what is important to you.

Main interview

1. **I'd firstly be interested to know what attracted you to this research project?**
   Prompts:
   - What led you to get involved? *(gives insight into motivations for taking part)*

2. **Can you tell me about a 'typical' day at work for you?**
   Prompts:
   - What does this look like?
   - What are the different aspects of a typical day at work for you?

3. **I'm keen to hear about your personal experiences of your work. Can you tell me about an experience related to your work that is particularly memorable for you? (*This can be recent or not, as long as you can easily recall it)***
   Prompts:
   - [Elicit details - how, who, what, where, when]
   - Describe what happened/ what happened next?
   - What went well / what didn't go well?
   - *If there is missing information*: Could you tell me about how you got from A to Z?
   - Can you tell me about how you reacted/ managed this? How did you cope? What was it about that that was helpful? Was there anything that didn't help?
   - How has this experience affected you?
     - Can you describe how this affected you at the time? Can you tell me how you felt?

    - What about if/how it has affected you in the long term? Can you tell me whether this has brought about any changes for you (either personally or professionally)?
    - What did you take away from this experience/ What did you learn from this?
  - Thinking about what you have told me about this experience, is there anything in particular about this experience that stands out to you? Why do you think this stands out to you?

4. **Thank you for telling me about that example, this seemed to centre around... [summarise what this centred around e.g. individual work, consultation, supervision, organisational issue]. Could you tell me about another example that stand out to you but that involved working at a different 'level' of the system?**
   - *Explore using previous prompts as appropriate.*
   - How does this differ from the previous example? Are there any similarities?

5. **What stands out most to you about the experiences you've spoken about?**
   - What do you think made you choose to talk about these examples?
   - What does it mean to you that you talked about these examples?

6. **Thinking over the areas we've talked about, what are your reflections?**
   Prompts:
   - What do you think about this?
   - What do you take from this?

Final question:

7. **Is there anything else that you feel is important to tell me that you've not had chance to say?**

Ending the interview

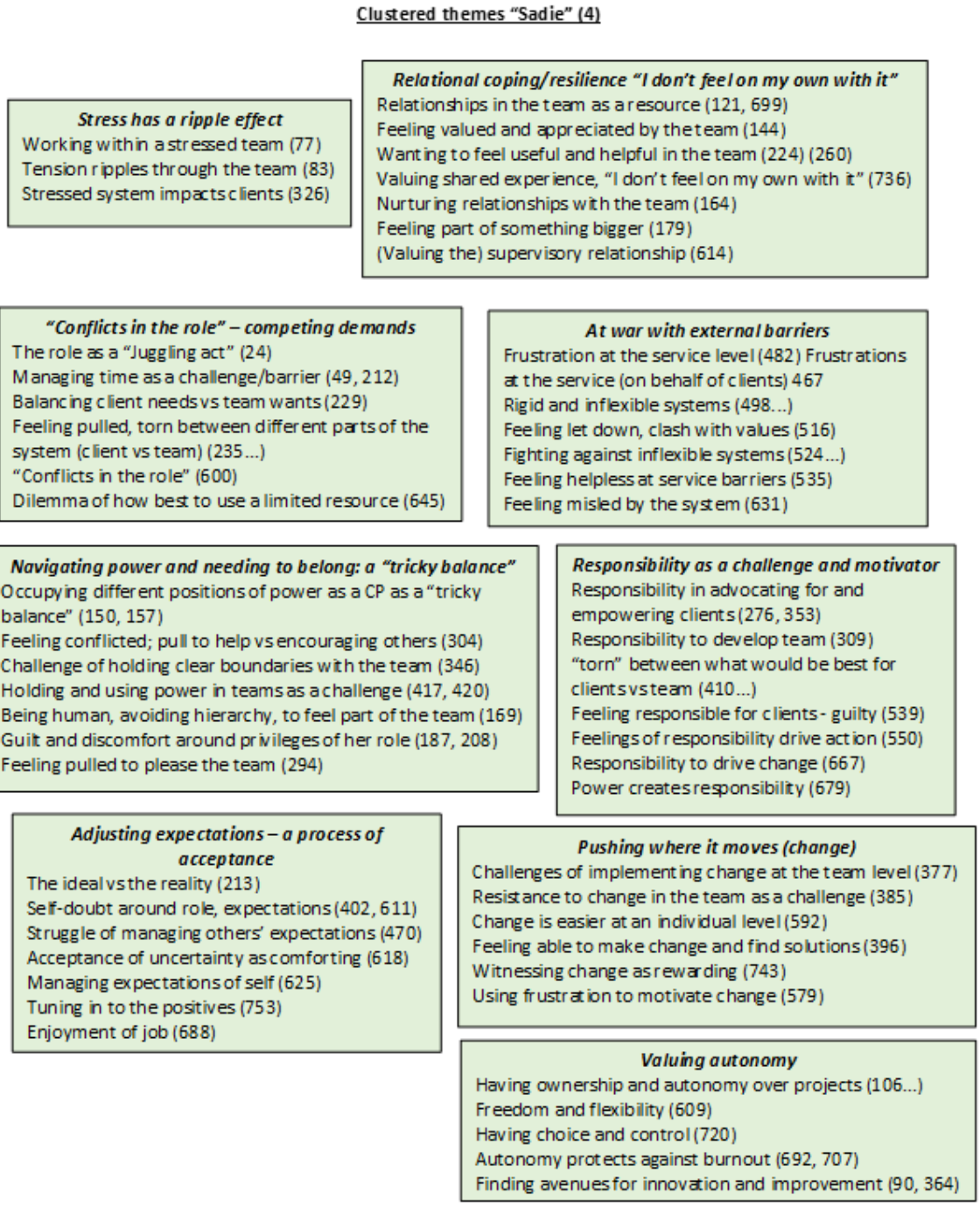
Thank you for talking to me today and taking part in the study.
[Signpost to any relevant support/resources if required]

Demographic/ contextual information to collect for each participant *[skip areas that have been answered during the interview].*
Gender:
Age:
Ethnicity:
Sexuality:
Disability:
Employment setting (e.g. CMHT, CAMHS, Health, LD):
Years since qualifying:
Weekly hours a week of work for the NHS:
Weekly hours of other work outside of NHS (private/ third sector):

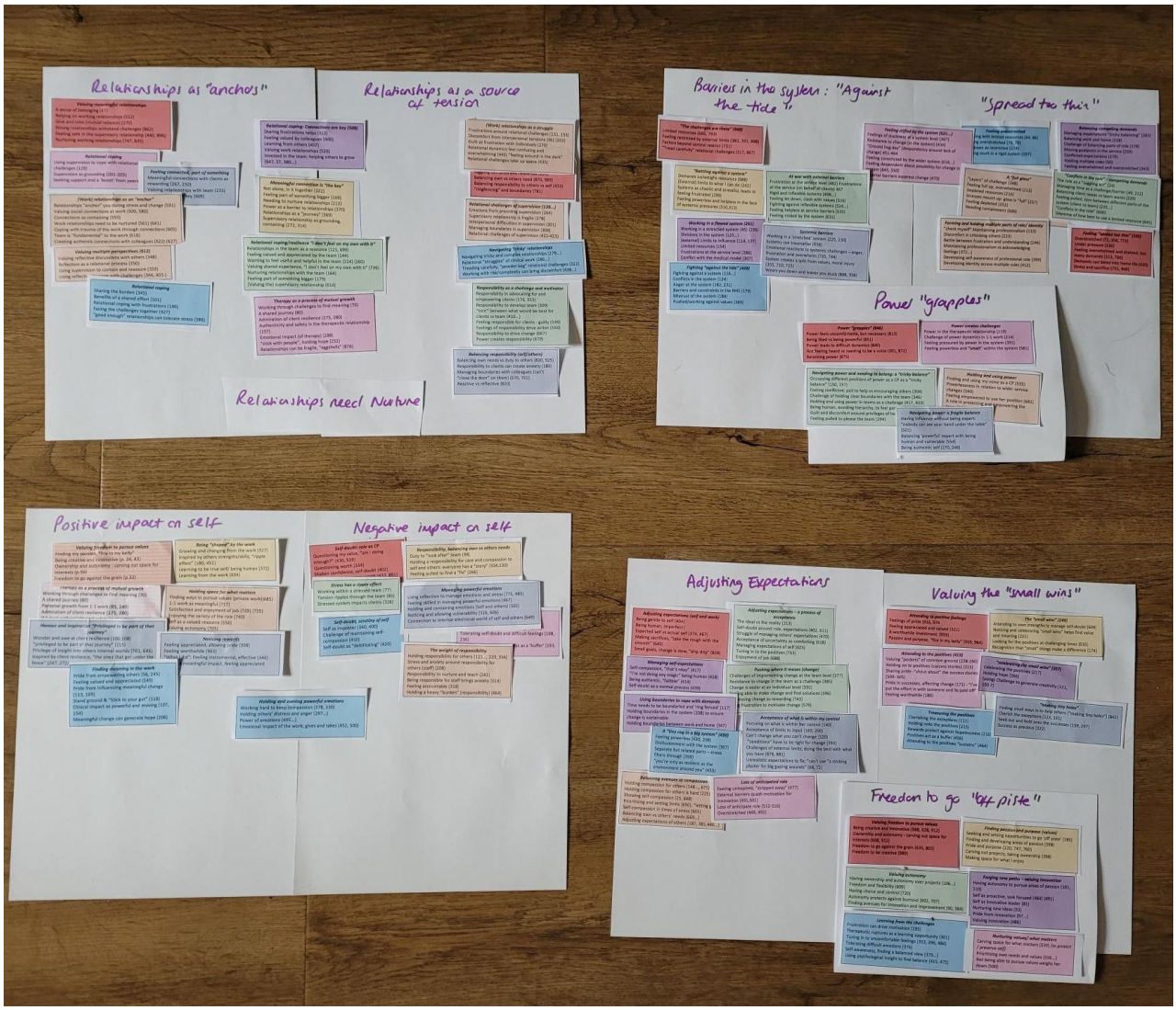
Appendix 8. Example of Analysis (Extract of Transcript for Sadie)

Analysis step 3: Emergent themes	Line no.	Transcript	Analysis step 1-2 Descriptive comments *Linguistic comments* Conceptual comments
Rigid and inflexible systems (498)	493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520	I just advised that she self-referred to primary care. To my, it's called [service name] to talking therapy there. I went through with her how to do that on the computer and it was all fine. Em and then about 5 weeks later I got em … I just got informed that she'd come back through to SPA and asked for my opinion. And I was like "Oh I wonder what's happened?" And [service name] had said no! They said that her difficulties were too complex! And it was really frustrating because … how they'd interpreted, she'd talked about hearing voices. Em but from our formulation and work together I think it was just her inner thoughts. Which had conflicting thoughts. And she kind of described them as voices but … I, I don't think they were in terms of a kind of psychosis. It was … it was her thoughts. But [service name] had kind of said "Oh no we can't deal with that! Back through to SPA." And then CMHT understandably, cos it wasn't with them had said no! And, and in the end she didn't, she didn't, she didn't have any service! Interviewer: Right. Participant: Em … and… and I know it was just really frustrating! Em … I've had, I mean and I suppose she was assessed again in SPA and I read the entry to make sure that I felt happy with it. And it was a very experienced nurse who went out and talked to her though and seeing that they came to a decision that she could manage and cope with the work that we'd done together and the strategies that we'd agreed. And if things deteriorated to go back to the GP, which I felt um well she's alright now but ultimately … I feel like she would have benefited from having an opportunity to … think more. But you know I only, really, my work can only bring a short term, you know like a short piece of work. There's a kind of preparation if you like and understanding. It wasn't intended to be the whole psychological therapy she was then going to have! And sometimes I even hear myself, and I hate it! But talking about private therapy? Just as a, saying to people if it's financially an option for you? And I hate that that happens! Em that I have to do that. But I kind of feel like sometimes people can't access psychology any other ways … Em there was another lady recently who was similar to this lady and the CMHT said no to. But I knew she'd previously been declined by [service name]. So	Sense of surprise, then shock they "said no!" *Talks with sense of passion and frustration, talking faster/ louder about this.* Feelings of frustration - feels let down on behalf of the client *"How they'd interpreted it"* – differences in understanding Criteria of services creates a barrier to access Rigidity and inflexibility in systems as a barrier Impact on clients of inflexible services "she didn't have any service" – let down, not held Frustration- anger at service limits Sense of frustration at clients not being appropriately supported Sense of this being 'enough' to keep this client safe but she would have benefitted from 'more' – bare minimum vs more meaningful work Value around accessibility of services- when she suggest private therapy --"hate it" (against her values) Working against values of ensuring accessible and meaningful service for clients (sense of injustice) Moral injury? *"argument on my hands"* – conflict from trying to advocate for clients, feels responsible for this?
Fighting against inflexible systems (524) **Feeling helpless at service barriers (535)** **Feeling responsible for clients, guilt (539)** **Feelings of responsibility drive action (550)**	521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551	had a real argument on my hands but eventually got her into CMHT. Just by saying where else is she supposed to go? We're saying that she's too unwell for primary care and not unwell enough for secondary care? It's just not right is it? Em so because she'd already been … it was on her notes and things that primary care had already said she didn't meet their criteria em … it felt like, but it felt like they were doing me a favour! [Laughs] And I was like it's not about me! But that's how it left me feeling like, they were like okay then, we will then! And I … it was like, it's not, let's, let's just think about this lady! And actually in reality where else is she going to get? So that's another frustration definitely between that interface between the [service name] team and the CMHT and primary care and the gaps that are there. Interviewer: Yes. Participant: which just is because of funding! And everyone's under pressure… Interviewer: Yes. And yes you've mentioned kind of feeling frustrated. Em are, are there any other feelings that come to mind when you think about that and- Participant: Really helpless. Really like… what else can I do? So really, again, I suppose questioning myself? Em thinking about, could I have done more? Feeling bad. Feeling guilty that I kind of prepared this lady for [service name] can help you. And then they said no! Em … angry sometimes! And thinking you know like oh gosh if this is, this is what it's like to work in the NHS! It's not … you know where there's people that aren't getting the care they need. Em so I talked about it quite a bit in my supervision and it was … taken actually to higher kind of levels to discuss, between services about that pathway. Em and kind of I found out that em … like referral criteria for the different services are kind of done independently. So like that primary care… and then there's secondary care and so if they're done independently there are going to be people in the middle aren't there? Interviewer: Mhm, Yes. Participant: Em … so hopefully I felt like … yes. Like I suppose I felt it quite personally when it was, particularly the lady that I'd done the work with. Em where thinking, feeling like I had an obligation or a need to make sure it was … discussed at higher levels to hopefully make some change? You know but yes I'd say frustration and like helplessness [laughs] are the main things!	Having to fight/battle for this- not easy, a struggle (Battling against inflexible services) *"It's just not right is it"*- it's wrong, unjust? Describes it feeling like "they were doing me a favour"- sense of appal and frustration at this. Had to fight against the limits, pushing for the client to be seen. Advocating for clients is important to her. Gaps are there- people fall though them. Having to fight against this. Lack of funding - Pressure in the system affects everyone *Speaks more slowly here- sense of sadness mirroring what she says around feeling helpless* Feeling guilty that clients can't access the support they need - sense of responsibility for this Sense of disappointment (behalf of clinets, not getting the care they need) Anger and disappointment at the organisational level (NHS) Proactive- trying to understand and solve this - Services don't work together- people fall between the cracks Feeling empowered to take this further vs a sense of helplessness around this Obligation – felt some personal responsibility Hopeful vs helpless *Laughs- to minimise frustration?*

Appendix 9. Clustered Themes for Sadie



Appendix 10. Photograph of Group Analysis



Appendix 11. Example Section of Superordinate Theme Table

Superordinate theme 2: Barriers and blocks- “up against” it		
Sub theme	**Emergent themes**	**Illustrative quotes**
Working "against the tide”	Feeling restricted by external limits Limited resources Factors beyond control (External) limits to what I can do Systems as chaotic and stressful, leads to feeling frustrated Feeling powerless in the face of systemic pressures Feeling stifled by the system Resistance to change in the system External barriers suppress change Fighting against inflexible system Working with limited resources Feeling misled by the system Feeling stuck in a rigid system Barriers and constraints in the NHS Conflicts in the system A flawed system Anger and mistrust towards the system Pushed to work against values Systemic pressures Feeling constricted, stifled Feeling worn down External barriers suppress change Us and them – feeling separate Disillusionment with the system Systemic barriers	*I’ve got quite a bit of freedom with it. Which feels quite novel I suppose … particularly in, you know particularly in the NHS (Jess 608) / It’s just there’s no, there’s no funding for it, it’s not commissioned, it comes down to money. We’d have umpteen psychologists in the service and we’d all specialise in one service if we could [merged] it’s just, it’s not doable! It’s just not really doable. Em … so really we should be funded to have, you know, specific day, you know full time day as official psychologist and more community psychologists em but it’s, it’s money (Jess, 383)* *That is amazing work, that should be happening. That should be free. That should be funded em by the Government and it should be just embedded. You know it shouldn’t be a one off 6 month, 6 month project (Katie, 687-689) / I think the biggest challenges are the, are the things that feel quite … out of our power you know? When I think about the … the education system. Like I mentioned a moment ago about the education system in our country … there’s so much pressure on each and every layer in that system. You know … from the top down to the... to make kids achieve and … and conform and I just don’t, I think that I was battling against that sometimes (Katie, 298) / I think sometimes it was just about naming that you know? That this is really hard, and that we are up against, we’re up against a system (Katie, 319)* *I kind of have and adjoining office with another psychologist, and we’re both kind of like … I think she made a joke like “oh are you feeling inspired now?” Or something like that! But it, in a way to suggest that like no-one’s inspired! [Laughter] … Em I did, I did say oh it reminds me of this away day that we had probably like almost a year ago. And we were like trying to talk about the same things like what, what do we offer? What can we do that’s innovative? But we haven’t done anything since … em things are the same since the away day... (Lucie, 430) / Cos there are the … frustrations em … in terms of the sort of service that maybe were, kind of I knew were there but hadn’t really kind of … spoken about to anyone. Again because like, what, what’s the point? [Laughs] (Lucie, 643)* *sometimes I even hear myself, and I hate it, but talking about private therapy? Just saying to people if it’s financially an option for you? And I hate that that happens! Em that I have to do that (Sadie, 516) / that feels a bit frustrating because it’s … em … it’s, you don’t have any less work to do! They just want you to squeeze it in because it’s cheaper! (Sadie, 630)* *it's a bit of a mixed bag, I feel really positive. But on the other hand, I'm thinking God, you know, if, if management don't support it, then, you know, it's just not sustainable. (Rose, 137) / it's tricky, balancing people's expectations and what psychological therapy actually is and what it, you know, what we can offer? I think though the frustration is more at a service level for that (Rose, 283)* *I think the way we set our services up? The structure of it. The kind of em … overly medicalised … set up. The lack of resources, the … lack of support sometimes. Em … that hasn’t been as much of an issue, like I’ve got really supportive manager it’s just I feel like we’re always kind of against the tide with it. And … em there isn’t always then the time to reflect on these things. There isn’t the time to do things differently. You’re a tiny cog in a big system that seems intent on squishing a lot of it down rather than kind of helping things run smoothly (Ali, 425) / but I think that was kind of what probably sparked me being a bit pissed off to be honest because I was like, if this is what you think then … do something about it! Do you know what I mean? Em … And yet you know we don’t have any more resources (Ali, 230) / The kind of you know … the pressure that the whole team are under, lack of resources. The kind of not being able to really work with people as kind of, and see them as people and what their needs are. And everything becomes a kind of … transaction. Em so it felt you know that there were things that would piss me off. (Ali 368) / you’re just really up against a system that … doesn’t really allow … for the things that you’re trying to do (Ali, 112)* *So it’s a reflection really about how … our Government and our society and the wider, you know … influences, our experiences of our jobs … em … I don’t think you can get away from that fact because I think we had appropriately funded services we wouldn’t, I wouldn’t have left! (Sara, 884) / I feel that we’ve moved so much further from that position now that we’re not able to do that level of early intervention. And so you get really stuck when you work and that’s part of the reason why I left. I just felt really stuck over and over again (Sara, 355)*

Appendix 12. Extracts from Reflective Journal

Following the interview with Jess: *"I wonder about my role as a trainee and similarity to participants as a 'double edged sword'. In one sense they may feel more at ease or comfortable with me and the assumed knowledge I may have into their working 'world'. But I also wonder about how participants may want to protect me from some the more challenging or difficult aspects of the work. She seemed to explicitly address this telling me she didn't want to "put me off". I think it will be important for me to remind future participants of the value in them speaking openly and of my role as a researcher in the process, rather than trainee."*
Following the interview with Lucie: *"I feel a little anxious after this interview and recognised worries in my mind around qualifying and how my experience of working in the NHS as a qualified Clinical Psychologist may not live up to my hopes. I feel like Lucie was quite brave in naming this as I think there could be pressure to feel positive and 'grateful' to work in this role considering the long journey it takes. I will need to keep this in mind during the analysis and consider how my own fears and feelings could shape how I make sense of this."*
Following the interview with Sara: *"I feel quite privileged to have spoken with Sara; she has a really unique perspective having worked in a health setting over the last year. Although covid has come up in some of my other interviews, for Sara I think this has really been a catalyst in some of the anger and frustration she named and her sense of having experienced a "moral injury". Interestingly this does seem to fit with ways participants have spoken of other aspects of their role that have contributed to distress. to them*
Following the first individual case analysis: *"At the start of the analysis I felt overwhelmed and uncertain about the process. I felt a pull to get it "right" and doubted the validity of my initial thoughts and notes. However, returning to the core principles of IPA reminded me that there are no "right" or "wrong" assumptions. This made me feel more comfortable and freer to write my initial thoughts with no rigid expectations. I also found it containing to save a separate version of the word document I was using each time I went in and made notes. Looking back on this I can see these develop and my increasing familiarity with the data leading to more interpretative reflections. I feel a sense of achievement having 'completed' the first analysis, and feel I've learned a great deal through putting these skills into practice for the first time. I feel a little less apprehensive about moving on to the next case and hope my confidence will increase as I continue.*

Appendix 13. Reflective Questions

Reflective Questions Adapted from Sue Mann (2005)
"Understanding and responding to distress in this work"

Distress as an opportunity to acknowledge values, wishes and hopes:

- Why was this conversation or series of conversations particularly significant to me?
- Does my upset or distress relate to certain beliefs, values, wishes, hopes that are important to me?
- Why are these values significant to me?
- How can I find connection with others around these values in my work and the rest of my life?
- What further action might I be able to take in relation to my work that would fit with these values?

Distress as an opportunity to consider workplace practices:

- What opportunities are available for workers to talk about the many experiences of the work?
- Of the many different stories of work that could be shared, what stories and whose stories are being privileged?
- How are the connections people have to what is important and of value to them shared in the workplace?
- What opportunities are there for celebration in relation to the achievements of the work?
- What opportunities are there to share moments of sadness, moments of beauty, moments of joy?

Distress as an opportunity to reconnect with local knowledge and relationships:

- How is the work valuing and building on the contributions of the community of people that might support those we are meeting?
- Are we finding ways to document, and create an audience for, the skills and knowledge that the people with whom we meet have demonstrated in responding to distress in their lives?

Distress as an opportunity to connect with others around the politics of the work:

- Who else would most likely to share this sense of distress/outrage?
- How could we come together to take some form of action as an outcome of this distress?
- How can the ideas and understandings gained in conversations inform organisational responses, policy, legislative systems, education of other workers?
- How can what is talked about in one on one conversations connect people with each other around their common experience of life in ways that enable broader social action?
- How are the politics of gender, class, race, age, ability, and heterosexual dominance being named and responded to within the conversations I have and within the organisation more broadly?

Distress as an opportunity to acknowledge that what is sometimes most distressing is not the stories we are hearing:

- Does the distress relate to the stories that are being heard in the [counselling] sessions or to other interactions in the workplace or home life?
- If other areas are the source of the distress, are there ways of seeking support in relation to this?

Distress as an opportunity to consider the real effects of different understandings of a therapist's distress:

- How can we take care so that the ways in which we understand our experience of therapeutic work honour the multiple contributions that [service users] who consult with us make to our lives and work?